

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26834

State File No. _____

3451

| | | | | | | | |
|---|--|--|--|---|---|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. _____ | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| a. COUNTY Jackson | | b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City | | c. LENGTH OF STAY (in this place) 26 yrs | | d. STREET ADDRESS (If rural, give location) 445 Donnelly | |
| e. STATE Mo | | f. COUNTY JACKSON | | g. CITY (If outside corporate limits, write RURAL and give township) Kansas City, | | h. _____ | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | 5. _____ | |
| a. (First) Frances | | b. (Middle) Braley | | c. (Last) Braley | | d. (Month) (Day) (Year) 8/9/49 | |
| 6. SEX Fem | | 7. COLOR OR RACE Wh | | 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 9. DATE OF BIRTH 7/2/1892 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Macon Co., Mo | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME John J. Jones | | | 13b. MOTHER'S MAIDEN NAME -----Smith | | | 14. NAME OF HUSBAND OR WIFE Acle Braley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Acle Braley, 445 Donnelly | | |
| 18. CAUSE OF DEATH (Enter only one cause; per line for (a), (b), and (c)) | | | | MEDICAL CERTIFICATION | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) spontaneous subarachnoid hemorrhage | | | | INTERVAL BETWEEN ONSET AND DEATH 28 hrs | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none, except angina pectoris Jan. '49 | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 330X | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | 21g. _____ | | 21h. _____ | |
| 22. I hereby certify that I attended the deceased from <u>May 6</u> , 19 <u>49</u> , to <u>August 9</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>August 9</u> , 19 <u>49</u> , and that death occurred at <u>7:20P</u> m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Frank E. Day (Degree or title) <i>Frank E. Day M.D.</i> | | | | 23b. ADDRESS 4314 E. 9th, K.C. Mo. | | 23c. DATE SIGNED 8/11/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 8/12/49 | | 24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem. | | 24d. LOCATION (City, town, or county) (State) Kansas City, Mo. | |
| DATE REC'D BY LOCAL REG. 8-11-49 | | REGISTRAR'S SIGNATURE <i>Seraldine Holmes</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil, K. C. Mo. | | ADDRESS | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

.....
working under my personal supervision.

Student
Student Embalmer

Signed.....

John P Steel

Licensed Embalmer No. *3625*

P. O. Address *K 6 Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.