

FILED OCT 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30123

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3987

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY McClain	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Bloomington	
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 605 East Olive St.	
3. NAME OF DECEASED (Type or Print) a. (First) Roy		b. (Middle) Joseph	
c. (Last) Brown		4. DATE OF DEATH (Month) (Day) (Year) 9 17 49	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-25-1893
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad labor	11. BIRTHPLACE (State or foreign country) Bloomington, Illinois
10b. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joseph Allan Brown		13b. MOTHER'S MAIDEN NAME Katherine White	
14. NAME OF HUSBAND OR WIFE Ida May Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World war 1	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Ida May Brown	
17. ADDRESS as above		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory failure - acute		INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DUE TO (b) Volvulus of ileum		1 week	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Pathologist	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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) 5703	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE A.E. Upsher		23b. ADDRESS 2800 Main St., K.C. Mo.	
23c. DATE SIGNED 9-17-49.		23d. NAME OF CEMETERY OR CREMATORY —	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9-17-49	
24c. LOCATION (City, town, or county) (State) Bloomington, Illinois		24d. NAME OF CEMETERY OR CREMATORY —	
DATE REC'D BY LOCAL REG. 9-17-49		REGISTRAR'S SIGNATURE Heraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.		ADDRESS KANSAS CITY, MO.	

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.

Signed _____

Max E. Meyer

Signed _____
Student Embalmer

Licensed Embalmer No. 45555

P. O. Address H. C. Inc.

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.