

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24657**
2901

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 70 yrs.		d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Medical Center		e. STREET ADDRESS (If rural, give location) 3835 Main (Netherlands Hotel)	

3. NAME OF DECEASED (Type or Print) a. (First) Daniel b. (Middle) Brown c. (Last) Brown		4. DATE OF DEATH (Month) (Day) (Year) 6-8-53	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-11-84
9. AGE (In years last birthday) 71 69		10. MONTHS 7	11. DAYS 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (City and State or Foreign Country) Montreal, Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Morris Brown	13b. MOTHER'S MAIDEN NAME Adelaide Brenner	14. NAME OF HUSBAND OR WIFE Cora
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Nettie Cohn	ADDRESS 7121 Main St.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 24 1/2
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cor Pulmonale		
	DUE TO (c) Chronic Emphysema		
II. OTHER SIGNIFICANT CONDITIONS due to old asthma Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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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?
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22. I hereby certify that I attended the deceased from **May 10, 1953** to **June 8, 1953** that I last saw the deceased alive on **June 8, 1953** and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Jack B. Brans	23b. ADDRESS 3309 W. Elder St. P.O. 53	23c. DATE SIGNED June 8-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-10-53	24c. NAME OF CEMETERY OR CREMATORY Rose Hill	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 6-10-53	REGISTRAR'S SIGNATURE Sheldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Louis Furl Home	ADDRESS K.C. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1328.0997

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.....
Signature of Student Embalmer

Signed *A. L. Louis*.....

Licensed Embalmer No. *3110*.....

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.