

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas		b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 3 days		c. CITY OR TOWN Kansas City	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Osteopathic Hospital		e. STREET ADDRESS (If rural, give location) 930 Ohio			

3. NAME OF DECEASED (Type or Print)		a. (First) ERSULA		b. (Middle) MAY		c. (Last) BROCKMAN		4. DATE OF DEATH (Month) (Day) (Year) Aug. 16, 1954		
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5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec. 17, 1882		9. AGE (In years last birthday) 62 7/1		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri				12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Jeff Blount		13b. MOTHER'S MAIDEN NAME Sarah Stubblefield		14. NAME OF HUSBAND OR WIFE Stanley Brockman			
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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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary Lue Reynolds, 4223 Pearl, K.C.Ks.			
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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.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage		DUE TO (b) Cerebral + generalized arteriosclerosis and hypertension		DUE TO (c) Leukemia		3 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		II. OTHER SIGNIFICANT CONDITIONS atherosclerotic heart disease + auricular fibrillation					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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 8/13, 1954 to 8/16, 1954, that I last saw the deceased alive on 8/16, 1954 and that death occurred at 2:12 A.M., from the causes and on the date stated above.

23a. SIGNATURE G.N. Gillum		(Degree or title)		23b. ADDRESS 926-5110th K.C.Mo		23c. DATE SIGNED 8/16/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-16-54		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, State or Foreign Country) Eldon, Missouri	
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DATE REC'D BY LOCAL REG. 8-16-54		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.		ADDRESS K.C.MO.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. G. H. Kilian

Epp - 2112 a

Osteopathic Hosp.
Gr. 1444

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..... *F. S. Walton*

Licensed Embalmer No. *21*

P. O. Address..... *KC Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.