

STANDARD CERTIFICATE OF DEATH

FILED MAR 13 1957

4598

STATE FILE NUMBER 882

Registration District No. 149 Primary Registration District 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 (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY 3048 0		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Length of stay in lb 8 yrs	d. STREET 1015 BRADWAY Ave location) ADDRESS Estil Hotel		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle W. Last BROWN			4. DATE OF DEATH Month 2nd Day 23rd Year 1957		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2- DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-16-89	9. AGE (In years last birthday) 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (City and state or country) Eldora, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Leroy Brown			14. MOTHER'S MAIDEN NAME Melissa Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 3-14-18 to 4-17-19-484-32-480		17. INFORMANT V.A. Hospital Records, K.C., Mo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, extensive, right and left lower lobes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) Pulmonary emphysema					INTERVAL BETWEEN ONSET AND DEATH 5211
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) /		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from February 21, 1957 to February 23, 1957 and last saw him live ^{die} on Death occurred at 12:20 pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE J. A. TURNER, M.D.			22b. ADDRESS V.A. Hospital, K.C., Mo.		22c. DATE SIGNED 2-24-57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE FEB-25-1957	23c. NAME OF CEMETERY OR CREMATORY IOWA SOLDIERS HOME CEMETERY		23d. LOCATION (City, town, or county) (State) MARSHALLTOWN IOWA
24. FUNERAL DIRECTOR D. W. Newcomer, Inc.		ADDRESS 1331 South Oak K.C., Mo.	25. DATE RECD. BY LOCAL REG. 2-25-57		26. REGISTRAR'S SIGNATURE Neal Marshall

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAY 8 1957

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 *Everett L. Smith*

Licensed Embalmer No. 50

P. O. Address K. C. M.

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.