

FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH28200  
STATE FILE NUMBER  
3726

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3726

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1			Length of stay in lb 20 YRS.		d. STREET ADDRESS (If outside, give location) 619 Highland		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clyde Browning				4. DATE OF DEATH Month 8 Day 7 Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-1887		9. AGE (In years last birthday) 70	10. F UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watch maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cherry Box Mo		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Mrs Clyde Browning		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service None		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs Clyde Browning 619 Highland				
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, Renal failure DUE TO (b) Multiple pulmonary infarcts, acute pyelonephritis DUE TO (c) diabetes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a),							INTERVAL BETWEEN ONSET AND DEATH 260X	
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 <input 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. I attended the deceased from Aug. 4, 1957 to Aug. 7, 1957 and last saw him alive on Aug. 7, 1957 Death occurred at 7:35 P. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) R. S. Burns, M.D.				22b. ADDRESS 24th & Cherry		22c. DATE SIGNED 8-8-57		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Removal		8-10-1957	Mt Hope Cemetery		Kansas City Kansas			
24. FUNERAL DIRECTOR Passantino Bros K C MO			25. DATE RECD. BY LOCAL REG. 8-9-57		26. REGISTRAR'S SIGNATURE Neva Marshall			

(Licensed Embalmer's Statement on Reverse Side)

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All diseases in Part I must be causally related.

B. I. Burns

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service



MAY 31 1962

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 *Leonard C Panantier*

Licensed Embalmer No. *4554*  
P. O. Address *15 C me*

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.