

Health, Welfare, Public Service

31731

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 9 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4431

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> 108 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5505 Scarritt</u>		Length of stay in lb <u>3 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>5505 Scarritt</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>WESLEY</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-14-1874</u>	9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>83</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Des Moines Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Frank Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Hansen</u>		14. NAME OF HUSBAND OR WIFE <u>Mattie Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 1892</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hester E. Holloway</u> Address <u>5505 Scarritt K.C. Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>central arteriosclerosis</u>		
	DUE TO (c) <u>generalized arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic heart disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <u>-</u> Month, Day, Year <u>-</u>					

20d. INJURY OCCURRED WHILE AT WORK <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 <u>12-17-53</u> , to <u>9-22-57</u> and last saw him alive on <u>9-20-57</u> Death occurred at <u>11:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE (Degree or title) <u>Wilson H. Miller, M.D.</u>				22b. ADDRESS <u>4620 Independence Ave Kansas City, Mo.</u>		22c. DATE SIGNED <u>9-23-57</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/24/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MM. Washington</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
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24. FUNERAL DIRECTOR <u>C.H. Blackburn & Son Inc.</u>		ADDRESS <u>K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-24-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	
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WILSON H. MILLER USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)



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 Bert B. Bennel

Licensed Embalmer No. 4656

P. O. Address Kelley 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.