

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35694

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4905

S. 300  
1-57

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 General #2		Length of stay in 1b 35 yrs.	d. STREET ADDRESS 1614 E. 10th		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Brooks Last Brooks			4. DATE OF DEATH October 18, 1957 Month Day Year		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 18th 1872	9. AGE (In years last birthday) 84 85	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian		10b. KIND OF BUSINESS OR INDUSTRY University K. C.	11. BIRTHPLACE (City and state or country) SELMA ALABAMA		12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME LOUIS BROOKS		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO. 496 32 6706A	17. INFORMANT Address Kissie Brooks, friend 1701 E. 10th		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with perforation.					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					1517
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 10-9-57 to 10-18-57 and last saw her alive on 10-18-57 Death occurred at 4:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) W.R. Peterson M.D.			22b. ADDRESS 600 East 22nd Street		22c. DATE SIGNED 10-21-57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Oct 23 1957	23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Mo
24. FUNERAL DIRECTOR ADDRESS ADKINS FUNERAL HOME KANSAS CITY, MO.			25. DATE RECD: BY LOCAL REG. 10-23-57	26. REGISTRAR'S SIGNATURE Neva Minshall	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
W.R. Peterson



deceased \_\_\_\_\_ first \_\_\_\_\_ last \_\_\_\_\_  
 date of death \_\_\_\_\_  
 place of death \_\_\_\_\_  
 cause of death \_\_\_\_\_  
 date of burial \_\_\_\_\_  
 place of burial \_\_\_\_\_  
 name of funeral home \_\_\_\_\_  
 name of embalmer \_\_\_\_\_  
 name of student embalmer \_\_\_\_\_  
 name of witness \_\_\_\_\_  
 name of witness \_\_\_\_\_  
 name of witness \_\_\_\_\_

**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 

10-15-24

10-15-24

Licensed Embalmer No. \_\_\_\_\_  
 P. O. Address \_\_\_\_\_

**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.