

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036288
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5075

FILED NOV 14 1958

S. 300
1-57

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|---|------------------------------|---|--|--|---|--|---|---|--------|------------------------------------|-------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before death) a. STATE Missouri b. COUNTY Jackson | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 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 2701 E. 60th | | | Length of stay in Ib 35 Yrs. | | d. STREET ADDRESS (If outside, give location) 2701 E. 60th | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First IRA Middle MELBORN Last BROWN | | | | 4. DATE OF DEATH Month 10 Day 26 Year 1958 | | | | | | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11 9 1882 | | 9. AGE (In years at birthday) 75 | | 10. FUNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Barber | | | 10b. KIND OF BUSINESS OR INDUSTRY Barber | | 11. BIRTHPLACE (City and state or country) D Chilhowee, Missouri | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | | | | |
| 13a. FATHER'S NAME Rev. Robert A. Brown | | | | 13b. MOTHER'S MAIDEN NAME Ditha Brown | | | | 14. NAME OF HUSBAND OR WIFE Elva L. Brown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 486-36-9409 | | 17. INFORMANT Address Mrs. Elva L. Brown 2701 E. 60th. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) H. E. V. D. | | | | | | | | DUE TO (c) 4:01 | | | | |
| 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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | | | | | | | | | | | |
| 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 12-1-43 to 10-26-58 and last saw her/him alive on 6-9-58 Death occurred at 9:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | |
| 22a. SIGNATURE <i>P. C. Quistgard</i> (Degree or title) md | | | | | 22b. ADDRESS 6741 Poplar Kchn | | | 22c. DATE SIGNED 10-27-58 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 10 28 1958 | | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills | | | 23d. LOCATION (City, town, or county) (State) Kansas City Mo | | | | |
| 24. FUNERAL DIRECTOR Floral Hills Mem. Chapels, Inc ADDRESS | | | | | 25. DATE RECD. BY LOCAL REG. 10-28-58 | | 26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i> | | | | | |

No symptoms will be listed. No diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

P. C. Quistgard

Handwritten notes in top right corner, possibly including "L. H. ..."



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 *R. J. Nofsinger*
Licensed Embalmer No. *5938*
P. O. Address *K.C. 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.