THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009303

STATE FILE NUMBER 1150

REC'D MAR 19 1959

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hosp. — Length of stay in Ib —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 8601 Woodland — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: ROBERT Middle: C Last: BRUNER

4. DATE OF DEATH Month 3 Day 1 Year 59

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH 1-24-1879

9. AGE (In years last birthday) 80 — 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) Retired Santa Fe Railway Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Seneca Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Robert D. Bruner ~~Unknown~~

13b. MOTHER'S MAIDEN NAME Celeste Jane Austin ~~Unknown~~

14. NAME OF HUSBAND OR WIFE Harriet Bruner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. —

17. INFORMANT Carl Bruner Address 3722 Olive K.C. Mo.

MEDICAL CERTIFICATION

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 — 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)
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 ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 2-9-59, to 3-1-59 and last saw her/him alive on 3-1-59
Death occurred at 1:45 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Abraham Gelperin (Degree or title)

22b. ADDRESS Gen. Hosp.

22c. DATE SIGNED 3-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 3-7-59

23c. NAME OF CEMETERY OR CREMATORY Forest Hill

23d. LOCATION (City, town, or county) (State) K.C. Mo.

24. FUNERAL DIRECTOR Sidman Funeral Home ADDRESS 4316 Troost K.C. Mo.

25. DATE RECD. BY LOCAL REG. 3-3-59

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Abraham Gelperin M.D.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 J. Robert Sidmon

Licensed Embalmer No. 4531

P. O. Address Lincoln City OR

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.