

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009819
STATE FILE NUMBER

FILED MAR 17 1959 Registration District No. 156 Primary Registration District No. 5572 Registrar's No. 70

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 Rural Prairie		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Kansas City <i>7800</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co. Hosp.		Length of stay in lb 4 mo.	d. STREET ADDRESS (If outside, give location) 220 S. Oxford
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Alma Brown			4. DATE OF DEATH Month Mar. Day 8, Year 1959	
5. SEX female	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 July 27, 1881	

9. AGE (In years) 77 (birthday)		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Lees Summit, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	---	---

13a. FATHER'S NAME George Bowlin	13b. MOTHER'S MAIDEN NAME Martha Stone	14. NAME OF HUSBAND OR WIFE Brent Brown
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT Marion Brown, 2540 Overton, Indep., Mo.
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart disease Generalized Arterio-sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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.) 4200
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Lees Summit, Mo	COUNTY _____	STATE _____
---	--	--	--------------	-------------

21. I attended the deceased from 11/11/59 to 3/8/59 and last saw her/him alive on 3/8/59 Death occurred at 1:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Shelby Haper M.D. (Degree or title)	22b. ADDRESS Lees Summit, Mo	22c. DATE SIGNED 3/9/59
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-10-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cem.	23d. LOCATION (City, town, or county) Kansas City, Missouri
--	-----------------------------	--	---

24. FUNERAL DIRECTOR Geo. C. Carson & Sons, Indep., Mo.	25. DATE RECD. BY LOCAL REG. 3/10/59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 7 1959

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 *Floyd E. Carson*

Licensed Embalmer No. *14199*

P. O. Address *Indy, 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.