

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

72-000708  
60-000708  
STATE FILE NUMBER

FILED VS FEB 10 1960

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 23

DED

1. PLACE OF DEATH a. COUNTY <i>Clay</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Clay</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>North Kansas City</i>		Length of stay in 1b <i>1 week</i>		c. CITY OR TOWN <i>Kansas City 1</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>North Kansas City Memorial Hosp</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>3119 Russell Road</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>T</i> Last <i>Brown</i>			4. DATE OF DEATH Month <i>2</i> Day <i>1</i> Year <i>60</i>					
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc.</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>10-16-89</i>	9. AGE (last birthday) <i>70</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Maker</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Linnus, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>		
13a. FATHER'S NAME <i>Bernard McElwain</i>			13b. MOTHER'S MAIDEN NAME <i>EMMA BRAILY</i>		14. NAME OF HUSBAND OR WIFE <i>Gordon Brown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>486-07-6500</i>	17. INFORMANT Address <i>Homer Coons 3119 Russell Rd.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute bronchopneumonia</i>							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) <i>General arteriosclerosis, Osteo-arthritis, Rheumatoid Arthritis, Rheumatic heart disease &amp; mitral stenosis</i>							PART III. Deceased was female was a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <i>6.00</i> a.m. p.m.		Month, Day, Year						
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 <i>January 14, 1960</i> to <i>February 1, 1960</i>				and last saw her/him live on <i>January 31, 1960</i>				
Death occurred at <i>6.00</i> a.m. on the date and time above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>John B. Wellman M.D.</i>				22b. ADDRESS <i>2736 S. Main St, Ma</i>		22c. DATE SIGNED <i>2-3-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>Feb 4-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>East Slope Cem.</i>		23d. LOCATION (City, town, or county) <i>Riverside</i>		23e. (State) <i>Mo.</i>		
24. FUNERAL DIRECTOR <i>D.W. Newcomer's Sons N.K.C.</i>				25. DATE RECD. BY LOCAL REG. <i>2-3-60</i>		26. REGISTRAR'S SIGNATURE <i>Marguerite Hudgens</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John D. Henick, Jr.  
Licensed Embalmer No. 4848  
P. O. Address K. B. 17

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.