

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019309

FILED VS MAY 27 1960

2703

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2703

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		Length of stay in 1b 52 Years	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 Trinity Lutheran Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 900 Ward Parkway		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A. Middle LAVERN Last BROWN			4. DATE OF DEATH Month May Day 15 Year 1960			
5. SEX Male	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 2/17/1892	9. AGE (last birthday) 68 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pres. & Manager		10b. KIND OF BUSINESS OR INDUSTRY Hicks-Brown Lumber Company	11. BIRTHPLACE (City and state or country) Schell City, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Charles Thomas Brown		13b. MOTHER'S MAIDEN NAME Mary Frances Messer		14. NAME OF HUSBAND OR WIFE Mildred 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. 487-03-6874	17. INFORMANT Address Mildred Brown, 900 Ward Parkway, K.C., 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) Severe toxemia due to left prostatic seminal vesiculitis 1 w/ DUE TO (b) Extreme prostatic hypertrophy DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Many Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Do not refer to the terms "Caecum" or "Colon" if deceased was female was there a pregnancy in last 90 days.) Caecum & sigmoid diverticulitis, Amoebiasis (Addison's) Ulcerum in relapse. Extensive fibrocalcicous lymphadenopathy					<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 SUICIDE / HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ 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 April 28, 1960 to May 15, 1960 and last saw him alive on May 15, 1960 Death occurred at 1:57 p m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE H. Goodson, MD (Degree or title)		22b. ADDRESS 720 Prof Bldg Kansas City 6 Mo		22c. DATE SIGNED May 17, 1960		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 17, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri		
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Missouri		ADDRESS	25. DATE RECD. BY LOCAL REG. 5-17-60	26. REGISTRAR'S SIGNATURE Irlva Minshall		

DOCUMENT

BY AFFIDAVIT OF
MEDICAL CERTIFICATION
H. H. Goodson, M.D.

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 _____

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.