

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

**60-030457**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4048

INDEXED

|   |  |   |   |   |   |  |   |       |  |
|---|--|---|---|---|---|--|---|-------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> COUNTY <b>JACKSON</b> |   |  |   |       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>   |  | Length of stay in 1b<br><b>64 Years</b>   |   | c. CITY OR TOWN <b>KANSAS CITY</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>VA HOSPITAL,</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>1604 E. 22nd St. Terr</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ALONZO</b> Middle <b>P.</b> Last <b>BROWN</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>5,</b> Year <b>1960</b>  |   |  |   |       |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>12-12-95</b>   | 9. AGE (last birthday)<br><b>64</b>   | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (City and state or country)<br><b>K.C., MO</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |       |  |
| 13a. FATHER'S NAME<br><b>Alonzo P. Brown Sr.</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Ella Shackelford</b>                      |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Ella Brown</b>   |   |       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WW I</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>196-09-3444</b>                             |   | 17. INFORMANT<br><b>Ruth Collins Daug. 5106 Gates, St Louis, Mo</b><br><b>Official Records VA Hospital, K.C., Mo.</b> |  |   |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right Retroperitoneal, Psoas and femoral abscess</b>                 |  |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |       |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Carcinoma of cecum with retroperitoneal perforation.</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)   |  |   |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |       |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |  |   |   |   |   |  |   |       |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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. attended the deceased from <b>August 4, 1960</b> to <b>August 5, 1960</b><br>Death occurred at <b>12:05 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |   |   |  |   |       |  |
| 22a. SIGNATURE (Degree or title)<br><b>T. F. Fritzen, M.D.</b>  |  |   |   | 22b. ADDRESS<br><b>VA Hospital, K.C., Mo.</b>   |   |  | 22c. DATE SIGNED<br><b>8-6-60</b>   |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/9/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Highland Cemetery</b>            |   | 23d. LOCATION (City, town, or county)<br><b>Kansas City, Mo.</b>  |  |   |       |  |
| 24. FUNERAL DIRECTOR<br><b>Mrs. Meek's Mortuary</b>   |  |   | ADDRESS<br><b>K. C. Mo.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>8-8-60</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>W.L. Sawyer</b>                                       |       |  |

(Licensed Embalmer's Statement on Reverse Side)

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Willard B. Pa...

Licensed Embalmer No. 501

P. O. Address KE

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