

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

5796 - 60-041900
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FILED VS. DEC 12 1960

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

STATE FILE NUMBER

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. 50 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 Blue Ridge Nursing Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS Netherlands Hotel 3835 Main St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAUDE Middle E. Last BROWNSON				4. DATE OF DEATH Month November Day 16, Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1883	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Vermillion, S.D.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph E. Fisher			13b. MOTHER'S MAIDEN NAME Emily M. Whitback			14. NAME OF HUSBAND OR WIFE Virgil Brownson		
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 Mrs. Alice L. McCormick Address Kansas City, Mo. 8858 E. 57th Terr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 7 Hours.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) Hypertensive Vascular Disease							12+ Years	
DUE TO (c) Cerebral Arteriosclerosis							12+ Years.	
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)						
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 checked="" 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 Nov. 1952 to 16 Nov. 1960 and last saw ^{her} him alive on 16 Nov. 1960 Death occurred at 7:00 P. m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Philip G. Kaul (Degree or title) M.D.				22b. ADDRESS 411 Nichols Road		22c. DATE SIGNED 11-17-1960		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-19-60	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri			
24. FUNERAL DIRECTOR Freeman Mortuary & Chapel ADDRESS Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 11-18-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Philip G. Kaul

Dr Phillip H. K...
Hoye James Billy

12:30 - 5 P.M.

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 J. P. Green

Licensed Embalmer No. 29

P. O. Address F. O. T.

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.