

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-040958

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5685

AMENDED

FILED DEC 1 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>21 days</u>	c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>106 N. Crestcent</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ombra</u> Middle <u>B</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-1904</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Rayville Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Fred Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Hazel Seagarden</u>		14. NAME OF HUSBAND OR WIFE <u>Ferne Brown</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-# 2</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Ferne Brown, Indep. Mo</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>		<u>Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of lung with metastasis.</u>	<u>months</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic heart disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
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20c. TIME OF INJURY Hour <u>7:00</u> a.m. <u>0</u> p.m.	Month, Day, Year
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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
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21. I attended the deceased from 1-4-57 to 11-13-61 and last saw him/her alive on 11-12-61
Death occurred at 7:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deputy or title) <u>V.B. Ballard MD</u>	22b. ADDRESS <u>411 Nichols Road Kansas City, Mo.</u>	22c. DATE SIGNED <u>11/16/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-15-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u>	ADDRESS <u>Woodland</u>	25. DATE RECD. BY LOCAL REG. <u>11-14-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

Dr. V. Bryce Gall
411 Nichols Rd.

Va. 1-4350

11:30 to 5:00

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 James E. Hackleman

Licensed Embalmer No. 4573

P. O. Address K.C. 9200

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.