

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044517

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6192 STATE FILE NUMBER

FILED DEC 22 1961

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived prior to institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>60 yrs</u>	c. CITY OR TOWN <u>KANSAS CITY</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>3200 NORLEDGE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4121 ST. JOHN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>GRESS</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>8</u> Year <u>1961</u>	
--	--	--	---	--

5. SEX <u>FEMALE</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>11-11-1884</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	IF UNDER 24 HR Hours <u>11</u> Min. <u>11</u>
----------------------	-------------------------------	---	------------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	--

13a. FATHER'S NAME <u>JOSEPH GRESS</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>WALTER V. BROWN</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not of unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>WALTER V. BROWN, 4121 ST. JOHN</u> Address
--	----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to, above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u> <u>12 years</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)	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
---	--

19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 10-24-61 to 12-8-61 and last saw her/him alive on 12-8-61
Death occurred at 2:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul Laureman</u> (Degree or title)	22b. ADDRESS <u>428 South White Ave</u>	22c. DATE SIGNED <u>12-8-61</u>
---	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>
---	---------------------------	--	---

24. FUNERAL DIRECTOR <u>MUEHLEBACH</u> ADDRESS <u>6800 TROOST</u>	25. DATE RECD. BY LOCAL REG. <u>12-9-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
---	---	--

(Licensed Embelmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF Paul Laureman MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Danny C Kerns, Student Embalmer No. 647
working under my personal supervision.

Student Danny C Kerns
Signature of Student Embalmer

Signed C. Johnson

Licensed Embalmer No. 4421

P. O. Address P.O. No

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.