MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

PARTMENT OF PUBLIC HEALTH AND WELFARE

62-005836
STATE FILE NUMBER

AMENDED

Registration District No. 59 Primary Registration District No. 40 97 Registrar's No. 24

FILED FEB 20 1962

1. PLACE OF DEATH
a. COUNTY: Cass
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Harrisonville
Length of stay in 1b: 40 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 401 Lake Ave
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Cass
c. CITY OR TOWN: Harrisonville
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 401 Lake Ave
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle E Last BROWN

4. DATE OF DEATH: Month Feb Day 15 Year 1962

5. SEX: Female
6. COLOR OR RACE: Colored
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Feb 17 1880
9. AGE (last birthday): 82
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Harrisonville Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Nelson Green
13b. MOTHER'S MAIDEN NAME: Cynthia Thomas
14. NAME OF HUSBAND OR WIFE: Oscar Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: THELMA ALLEN Address: Harrisonville Mo

MEDICAL CERTIFICATION

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
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): hypertension
DUE TO (c): Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH: 4 days

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1955 to 2-15-62 and last saw her/him alive on 2-14-62
Death occurred at 9 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Howard S. Jones MD (Degree or title)
22b. ADDRESS: Harrisonville Mo
22c. DATE SIGNED: 2-17-62

22e. BURIAL, CREMATION, REMOVAL (Specify): Burial
22f. DATE: Feb 19 1962
23. NAME OF CEMETERY OR CREMATORY: Orient Cemetery
23d. LOCATION (City, town, or county) (State): Harrisonville Mo
24. FUNERAL DIRECTOR: Funnenburgers ADDRESS: Harrisonville Mo
25. DATE RECD. BY LOCAL REG.: Feb 17 1962
26. REGISTRAR'S SIGNATURE: Per Ray J. Lebow

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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_____ Signed Ernest Zimmerburg

Signature of Student Embalmer

Licensed Embalmer No. 3368

P. O. Address Harrisonville

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.