

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006385

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1310 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 15 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in lb <u>Inda. 23 days</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>3510 College</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3510 College</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ROSALIND SHERON BROWN</u>			4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>63</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-63</u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE (last birthday) Months <u>7</u> Days <u>23</u>
11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>LEO M. BROWN Jr.</u>		13b. MOTHER'S MAIDEN NAME <u>ROSALIND COX</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</u>		17. INFORMANT Address <u>ROSALIND BROWN 3510 COLLEGE, K.C., MO.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>by smothering</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>[REDACTED]</u> DUE TO (c) <u>[REDACTED]</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho-Pneumonia</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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Under bed covers while asleep.</u>	
20c. TIME OF INJURY Hour <u>6:15</u> a.m. <u>PM</u> Month, Day, Year <u>2/27/63</u>	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.) <u>3510 College</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson, Mo.</u>	
21. I attended the deceased from _____, to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Inspector in Charge, Deput. Coroner</u>		22b. ADDRESS <u>1618 Lydia Ave.</u>	
22c. DATE SIGNED <u>2/27/63</u>		23. NAME OF CEMETERY OR CREMATORY <u>LINCOLN CEMETERY</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-1-63</u>	
23c. LOCATION (City, town, or county) <u>KANSAS CITY</u>		23d. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Mr. C. E. Davis</u>		25. DATE RECD. BY LOCAL REG. <u>2-27-63</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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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 John R. Sidman

Licensed Embalmer No. 4531

P. O. Address Kansas City, Mo

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.