

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

21498

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. 2846
 City Kans. City Mo. (No. old City Hospital) St. _____ Ward _____

2. FULL NAME

Major Brown
 (a) Residence No. 9018 E. 16th St. St. 2 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>42</u>		<u>6</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Texas
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lena Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Texas
 (STATE OR COUNTRY)

14. INFORMANT Lena Brown
 (Address) 918 E. 16th St.

15. FILED 7/19 27 M. M. Crowe
 REGISTRAR ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-10 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-1 1927, to 7-10 1927, that I last saw him alive on 7-10 1927, and that death occurred, on the date stated above, at 2:45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary T. B.

CONTRIBUTORY (SECONDARY) 31
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) H. M. Smith, M. D.
7/11 1927 (Address) Kc Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leeds Cemetery **DATE OF BURIAL** 7/20 1927

20. UNDERTAKER Wed. Appleton & Jones **ADDRESS** 1600 E. 19

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

