

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

Do not use this space.

6477

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township KAW Primary Registration District No. 1002  
City KANSAS City (No. 5719 Mersington)

File No. ✓  
Registered No. 657  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Stella Gertrude Brown

(a) Residence No. 5719 Mersington St. 16 Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 10, 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
19 4 26

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer) 82B  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Jackson Co. Mo.

10. NAME OF FATHER Robert Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Lawrence Co. Ohio.

12. MAIDEN NAME OF MOTHER Gertrude Day

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ill.

14. INFORMANT M. R. H. Brown (Address) 5719 Mersington

15. FILED 2-8-29 M. M. Crowe REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 6, 1929

17. I HEREBY CERTIFY That I attended deceased from Apr 28 - 27 - 29 to Feb 6 - 29 - 29 that I last saw her alive on Feb 6 - 29 and that death occurred, on the date stated above, at 5:50 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Paralysis of Brain from intracerebral pressure from acute edema of Brain

CONTRIBUTOR (SECONDARY) Began with Myeloma on right upper chest followed by general Metastasis

18. WHERE WAS DISEASE CONTRACTED at home  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF May 19 1927  
NO DATE OF Oct 19 28

20. WHAT TEST CONFIRMED DIAGNOSIS? Surgical & Laboratory  
(Signed) Walter W. Clemmow, M. D.  
2-7-1929 (Address) 29 E. 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 Forest Hill DATE OF BURIAL 2/8 29

20. UNDERTAKER W. H. H. Co. & Sons ADDRESS let's go

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399 File No.....  
Township..... Primary Registration District No. 1002 Registered No. 637  
City J. City (No..... St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration) ..... yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT..... (Address)

15. FILED 2/8 29 M. M. Cronin REGISTRAR  
Asor

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 6 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... ally on..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Qualrants of brain  
..... (duration) ..... yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Began with myeloma  
on right upper Chest followed by  
general metastasis  
18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECED DEATH? 49 DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS? Microscop

(Signed) Walter M. Cronin, M. D.  
, 19..... (Address)

\*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

S-6477