

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

Do not use this space.

**12927**

**1. PLACE OF DEATH**

County Lawson  
Township Law  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002  
(No. Kansas City Gen Hosp)

File No. \_\_\_\_\_  
Registered No. 1856  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Clyde Brown  
(a) Residence. No. 212 West 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 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Divorced</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>7-14 1891</u>		
7. AGE	YEARS	MONTHS
	<u>38</u>	<u>9</u>
		<u>14</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work. <u>Waiter</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-28 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-29 1930 to 4-28 1930 that I last saw him alive on 4-28 1930 and that death occurred, on the date stated above, at 9:35 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Syphilis of central nervous system  
Tuberculosis of lungs  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 28  
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clin + Lab Find  
(Signed) P. E. Williams M. D.  
4-29-1930 (Address) Dept K.C. Gen. Hosp

\*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.

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

10. NAME OF FATHER C. H. Brown

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

12. MAIDEN NAME OF MOTHER West/Kear-

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

14. INFORMANT Reverend Clerk  
(Address) Kansas City Gen Hosp

15. FILED 4/29 1930 M. M. Corbue  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Chellin Kans-  
DATE OF BURIAL 4-30 1930

20. UNDERTAKER O. J. Mast  
ADDRESS 1950.15

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.

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