

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

Do not use this space.

34695

1. PLACE OF DEATH

County Jackson

Registration District No. _____

Township Kaw

Primary Registration District No. _____

City Kansas City (No. Low Hosp # 2)

File No. _____

Registered No. 4450

St. _____

Ward 4450

2. FULL NAME Lucille Brown

(a) Residence, No. 627 Cottage Lane St. 1 Ward. _____

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-29-1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
30 8 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Dan Brown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

MOTHER 15. MAIDEN NAME Tempsil Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Regard, Clerk Low Hosp # 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE 11-8 1921

19. UNDERTAKER (ADDRESS) D. M. Miller 1820 E. 15th

20. FILED 11-6 1931 M. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-27-1931

22. I HEREBY CERTIFY, That I attended deceased from 10-3-1931, to 10-27-1931
I last saw her alive on 10-27-1931 Death is said to have occurred on the date stated above, at 12:15 a.m.
The principal cause of death and related causes of importance were as follows:

23A
Pulmonary tuberculosis
Other contributory causes of importance:
DB

Name of operation _____ Date of _____
What test confirmed diagnosis? Feb + Culture Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) D. M. Miller, M. D.
(Address) Low Hosp # 2

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.

