REC'D FEB 20 1939

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

Do not use this space. 988

Registered No. 1

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kansas
(c) City Kansas City
(d) Street No. T.C. Gen Hosp St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds.
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No.
Primary Registration District No.

2. PRINT FULL NAME Robert B Braun
(a) Residence, No. 2819 E 39th St St.
(Usual place of abode, if no street address, write county or city)
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-3-1886

7. AGE: Years 52 | Months 2 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Westport Mo

FATHER
13. NAME Jacob Braun
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER
15. MAIDEN NAME Caroline Jung
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT John D. Evans
(ADDRESS) 3547 Belleflaine

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Moriah DATE 1-3, 1939

19. FUNERAL DIRECTOR (NAME) D. W. Neuromen Sons
(ADDRESS) K.C. Mo

20. FILED Jan 1, 1939 M. McCrone
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-29, 1938 to 1-1, 1939
I last saw him alive on 1-1, 1939. Death is said to have occurred on the date stated above, at 7:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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) S. H. De Mana, M. D.
(Address) Supt T.C. Gen Hospital

(Licensed Embalmer's Statement on Reverse Side)

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.

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.