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.

DEC MAR 9 1939

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

5702
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
or
(c) City Kansas City
Registration District No. 399
Primary Registration District No. 1002
Registered No. 901
(d) Street No. Gen. Hospital #2 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.

2. PRINT FULL NAME Wesley E. Brown
(a) Residence, No. 1103 Woodland 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 Male
4. COLOR OR RACE negro
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) Feb 24, 1939
7. AGE YEARS MONTHS DAYS 1 If LESS than 1 day, 10 hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Infant
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) Kansas City Mo
FATHER
13. NAME Chester Brown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo
MOTHER
15. MAIDEN NAME Alice Goodin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Windsor Mo
17. INFORMANT (ADDRESS) Chester Brown 1103 Woodland
18. BURIAL, CREMATION, OR REMOVAL
PLACE Blue Ridge DATE Feb 28, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Sterling Bills 1811 E 12th St K.C. Mo
20. FILED 2/28, 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-25-39, 19

22. I HEREBY CERTIFY, That I attended deceased from Dyspnea Cor, 19 to , 19
I last saw [illegible] alive on , 19 Death is said to have occurred on the date stated above, at 12 noon.
The principal cause of death and related causes of importance were as follows:
Prematurity & Immaturity
159
Date of onset

Other contributory causes of importance:

Name of operation Insp Date of
What test confirmed diagnosis? Was there an autopsy?

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) Russell W. Kerr, M. D.
(Address) K.C. Mo

(Licensed Embalmer's Statement on Reverse Side)

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 co
with the above constitutes grounds for revocation of license.)

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