

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'D JUN 8 1939

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

17639
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. 3909 Central Registered No. 2041
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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.
6 20 Mrs. Alice Brosi
 2. PRINT FULL NAME
 (a) Residence, No. 3909 Central St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 12, 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>81</u>	<u>6</u>	<u>4</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as 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) Quincy Illinois

FATHER

13. NAME Unknown

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Mrs. Grace M. Tolle 3909 Central

18. BURIAL OR CREMATION PLACE OR REMOVAL PLACE Quincy, Ill. DATE May 18, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. V. Lindsey & Son 3811 Broadway

20. FILED May 16, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 14, 1939, to Same, 1939.
 I last saw him alive on May 14, 1939. Death is said to have occurred on the date stated above, at 1 AM.
 The principal cause of death and related causes of importance were as follows:
Heart
Generalized Arteriosclerosis
Diabetes
 Date of onset 5-13-39

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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? No.
 If so, specify _____
 (Signed) Robert M. Myers, M. D.
 (Address) 1025 Piotta Bldg

THE STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH SERVICES
DIVISION OF FUNERAL SERVICES

*Dr. Roberts' wife
Ruth
1-5*

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

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