

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.

SEP 6 1939

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

28385
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kaw Primary Registration District No. 100

(c) City Kansas City, Mo. (d) Street No. 2728 Forest 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.

2. PRINT FULL NAME James R. Brockman

(a) Residence, No. 2728 Forest St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12, 1852

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	86	8	17	

OCCUPATION

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

9. Industry or business in which work was done, as saw mill, bank, etc. farmer

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 Jacob Brockman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

MOTHER

15. MAIDEN NAME Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT J. T. Brockman
(ADDRESS) 555 Stonewall Court

18. BURIAL, CREMATION, OR REMOVAL PLACE Salisbury, Mo. DATE Aug 30 1939

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

20. FILED 87 29 19 39 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 29, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 15 1939 to Aug 26 1939
I last saw him alive on Aug 26 1939 Death is said to have occurred on the date stated above, at 1:00 AM.
The principal cause of death and related causes of importance were as follows:
Chronic Interstitial Nephritis Date of onset 1 yrs

Other contributory causes of importance:
Chronic Insufficiency

Name of operation None Date of _____
What test confirmed diagnosis Salivary Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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 _____
(Signature) [Signature] M. D.
(Address) 2728 Forest St. Bk. B. C. Mo.

Dr. J. O. Brown
6241 E. 15
Case used in mem.

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.