

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11197
Registrar's No. 182

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-31-1-10-40
(Specify whether
In this community 56
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1823 Highland Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William Brown
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 1 16 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 11 25 hr. _____ min.

9. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation None Musician

11. Industry or business _____
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address General Hospital No. 2.

17. (a) Burial (b) Date thereof Jan. 15, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Atkins Bros.
(b) Address 1729 Lydia

19. (a) Jan 15, 1940 (b) W. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 1 day 10
year 40 hour 5 minutes 15 A.M.

21. I hereby certify that I attended the deceased from 10-31-, 1939 to 1-10-, 1940
that I last saw him alive on 1-10-, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Right Coronary Occlusion

Due to 94-13

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Above Mentioned

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury !

23. Signature W. M. Brown (M. D. or other)
Address General Hospital #2 Date signed 1-11-

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

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 *Isaac Jerome Manlove*

Licensed Embalmer No. *3994*

P. O. Address *1120 E. 23rd St*

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.