

WHILE PLAIN. USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: General Hospital No. 2

(d) Length of stay: In hospital or institution 1-9-40-1-20-40

In this community 21 years

3. (a) PRINT FULL NAME Lucille Brown

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Augustus Brown

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased 2 26 1897

8. AGE: Years 42 Months 10 Days 25

If less than one day hr. min.

9. Birthplace Tennessee

10. Usual occupation At Home

11. Industry or business 1

MOTHER FATHER { 12. Name Guy

13. Birthplace Tenn.

14. Maiden name Unknown

15. Birthplace Unknown

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital No. 2.

17. (a) burial (b) Date thereof 1-24-40

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director 3

(b) Address 1729 Lydia

19. (a) Jan. 24, 1940 (b) McIn Crow

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City

(d) Street No. 1602 E. 11th St.

(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 20

year 40 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from 1-9- 1940, to 1-20 1940

that I last saw her alive on 1-20- 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho-Pneumonia

Due to 11/1

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature 3 (Specify type of place) \_\_\_\_\_

Address General Hospital #2 (a) Means of injury \_\_\_\_\_

Date signed 1-20

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

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**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 Wenzel

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.**