

FILED APR 12 1940
399

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1084

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Jackson

(a) County Kansas City

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2319 Harrison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 37 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Theodore Brodie 630

3. (b) If veteran, name war None 3. (c) Social Security No. 487-05-8123

4. Sex M 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mabel Brodie 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased September 22, 1902
(Month) (Day) (Year)

8. AGE:	Years <u>37</u>	Months <u>5</u>	Days <u>14</u>	If less than one day hr. min.
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9. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Bunting Hardware Co.

MOTHER FATHER { 12. Name Charles Brodie 1

13. Birthplace Nashville Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name May Calloway

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

16. (a) Informant Charles Brodie

(b) Address 830 Euclid

17. (a) burial (b) Date thereof 3/11/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director William T. Brown
(b) Address 1729 Lydia

19. (a) Mch 9, 1940 M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

Kansas City

(c) City or town 0 (If outside city or town limit, write "RURAL")

2319 Harrison

(d) Street No. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from Oct. 10
1940 to March 6, 1940

that I last saw alive on Mar. 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute

Congestive Failure

Due to _____

Due to Hypertrophy Heart

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy none 9573

Underline the cause to which death should be charged statistically.

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. T. Brown (M. D. or other) _____
Address 1830 E. Ave Date signed 3/10/40

Turner,

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 Masipove

Licensed Embalmer No. 3997

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9650

Registrar's No. 1084

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution d 319 Harrison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Theodore Brodis

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Cool 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 37 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. d 319 Harrison
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute congestive heart failure

Due to hypertrophy of heart

Due to _____

Other conditions (Include pregnancy within 3 months of death) none

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 P. C. Turner (M. D. or other) _____

Address 1830 Vine Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.

1940
S-9650