

MED JUN 17 1940

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. _____

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:
Catherine Hale Home for Blind Women
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 years
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 2918 Tracy
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th
year 1940 hour 12:45 minute A M.
21. I hereby certify that I attended the deceased from May 6
1940 to May 8 1940
that I last saw her alive on May 8 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Head injury in fall
down stairs May 6-40
Other conditions 18/20
(Include pregnancy within 3 months of death) 10

Duration 3 da
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations: _____
Of autopsy: _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence May 6-1940
(c) Where did injury occur? Russian Bldg. Jackson Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home. Home for the Blind
While at work? No (Specify type of place) (e) Means of injury Struck head
23. Signature W. D. Davis M.D. (M., D., or other)
Address 402 Washington Bldg Date signed 5-9-40

3. (a) PRINT FULL NAME Miss Nannie Price Brown (LST)

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased October 23, 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 6 16 hr. min.

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

10. Usual occupation at home

11. Industry or business X

12. Name James Brown

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

14. Maiden name Jane Price

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

16. (a) Informant Catherine Hale Home

(b) Address 2918 Tracy, K. C., Mo.

17. (a) Burial (b) Date thereof 5- -40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warsaw, Kentucky

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) May 10, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Dr. A. W. Davis

William B. G. G.
21 71 7. 1904

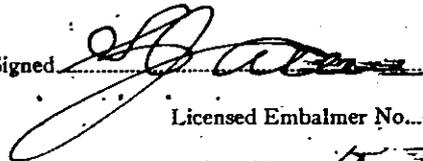
STATEMENT BY LICENSED EMBALMER

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. 1415

P. O. Address T. C. 170

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.