DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUN 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17654

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2181

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
(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 5-2-40-5-25-40 (Specify whether years, months or days)

In this community 1 year

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. 1731 Park Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME: Harold Brown

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

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 (Month) 13 (Day) 1939 (Year)

8. AGE: Years 1 | Months 4 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace: Kansas City (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Harold Brown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Irene Simpson
15. Birthplace: Lawrence (City, town, or county) Kansas (State or foreign country)

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

(b) Address: General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-28-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Lincoln Cem

18. (a) Signature of funeral director: H. B. Moore

(b) Address: 1820 E. 18th St.

19. (a) May 28, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 25 year 40 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from 5-2- 1940 to 5-25- 1940 that I last saw h 1m alive on 5-25- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebro-Spinal Meningitis	
(Pneumococcal in origin.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: Above Mentioned

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? (Specify type of place)

While at work? Means of injury:

23. Signature: [illegible] (M. D. or other)

Address: Gen. Hosp. #2 Date signed: 5-27-

(Licensed Embalmer's Statement on Reverse Side)

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 H B Moore, Registered Apprentice No. ..... working under my personal supervision.

Signed H B Moore

Licensed Embalmer No. 2410

P. O. Address K.C. MO.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.