

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **20928**  
Registrar's No. **2545**

Registration District No. **399** Primary Registration District No. **1002**

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: Northeast Hosp  
(d) Length of stay: In hospital or institution 12 days  
In this community non-accident

**3. (a) PRINT FULL NAME** Mildred Hill Brown  
**8. (b) If veteran, name war** no **8. (c) Social Security No.** no

**4. Sex** 7 **5. Color or race** W **6. (a) Single, widowed, married, divorced** married  
**6. (b) Name of husband or wife** Wallace E. Brown **6. (c) Age of husband or wife if alive** 30 years  
**7. Birth date of deceased** Sept 10 - 1911

**8. AGE:** Years 28 Months 9 Days 2 If less than one day hr. min.

**9. Birthplace** Saline Co. Mo.

**10. Usual occupation** Home work

**11. Industry or business** House  
**12. Name** Charles A. Hill  
**13. Birthplace** Lafayette Co. Mo.  
**14. Maiden name** Thelma Lee  
**15. Birthplace** Calhoun Mo.

**16. (a) Informant's own signature** Wallace E. Brown  
**(b) Address** 207 N. Pleasant, Indip. Mo.

**17. (a) Burial** **(b) Date thereof** 6-24-40  
**(c) Place: burial or cremation** Lee's Summit Mo.

**18. (a) Signature of funeral director** N. B. Ganges  
**(b) Address** Lee's Summit Mo.

**19. (a) June 23, 1940** **(b) Registrar's signature** M. M. Brown

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson  
(c) City or town Independence Mo.  
(d) Street No. 207 So. Pleasant  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month 6 - Day 22 - Year 40  
hour \_\_\_\_\_ minute 30 M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.  
**Immediate cause of death** Generalized Peritonitis  
**Due to** Acute Salpingitis - n.m.o.  
**Due to** \_\_\_\_\_  
**Other conditions** 39 B  
(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? \_\_\_\_\_ (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** Russell **(M. D. or other)** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Date signed** \_\_\_\_\_

**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 *H. B. Langeford*

Licensed Embalmer No. *3203*

P. O. Address *Leis Summit*

**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.**