

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1002

State File No. \_\_\_\_\_

24031

Registrar's No. \_\_\_\_\_

2641

AUG 14 1940 399

Primary Registration District No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Jackson 1  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Conley Clinical Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
(Specify whether years, months or days) 49 Years

8. (a) PRINT FULL NAME Charles R. Brown (b) 6573. (b) If veteran 192-18-1473 name war No 3. (c) Social Security No. Unknown4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Rose Brown 6. (c) Age of husband or wife if alive 55 years7. Birth date of deceased July 6 1880  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
59 11 25 hr. min.9. Birthplace No Record 7  
(City, town, or county) (State or foreign country)10. Usual occupation Pipe Fitter 1111. Industry or business Plumber12. Name Henry Brown 113. Birthplace England  
(City, town, or county) (State or foreign country)14. Maiden name Marilda Winters  
(City, town, or county) (State or foreign country)  
15. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Rose Brown(b) Address 5825 East 10th. St. K.C. Mo.17. (a) Burial (b) Date thereof July 2, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Marys Cemetery18. (a) Signature of funeral director Sheil Funeral Home(b) Address 6606 Independence Ave. K.C. Mo.19. (a) July 1, 1940 (b) M. M. Browe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5825 East 10th. Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1st  
year 1940 hour 1:45 AM minute \_\_\_\_\_ A. M.21. I hereby certify that I attended the deceased from June 27, 1940, to July 1, 1940that I last saw him alive on June 30, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Angina pectoris  
Due to Coronary occlusion  
Due to Undetermined

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

23. Signature R. C. Raymond Hall (Specify type of place) (e) Means of injury 3  
While at work? \_\_\_\_\_ (M. D. or other) \_\_\_\_\_Address 2105 Indep Ave Date signed 7/1/40

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.....

*Joe B. Yoder*....., Registered Apprentice No. *238*  
working under my personal supervision.

Signed.....  
*J. P. Shiel*  
Licensed Embalmer No. *3625*  
P. O. Address..... *K. C. Mo.*

**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.**