No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 27559

FILED SEP 5 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3192

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

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: St Josephs Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether

In this community 5 Days 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 limits, write "RURAL")

(d) Street No. 3939 Garfield (If rural, give location)

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

3. (a) PRINT FULL NAME Lynn Edward Brown 650

3. (b) If veteran, name war —

3. (c) Social Security No. No

4. Sex M

5. Color or race W

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 8 (Month) 8 (Day) 40 (Year)

8. AGE: Years — Months -- Days 5 If less than one day ..... hr. ..... min.

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

10. Usual occupation

11. Industry or business —

FATHER
12. Name Edward F Brown
13. Birthplace Pittsburg (City, town, or county) Ks. (State or foreign country)

MOTHER
14. Maiden name Virginia Hord
15. Birthplace Hardin (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Edward F Brown

(b) Address Kansas City Mo

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 8-12-40 (Month) (Day) (Year)

(c) Place: burial or cremation Gravette Ark

18. (a) Signature of funeral director Family

(b) Address Gravette Ark.

19. (a) Aug. 12, 1940 (Date received local registrar) (b) M. McCrane (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 8 day 12-40 year ..... hour ..... minute 8:30 A M.

21. I hereby certify that I attended the deceased from 8-8-40 8-12-40, 19....; that I last saw him alive on 8-12-40, 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to Prematurity Immaturity

Due to 159

Other conditions (Include pregnancy within 3 months of death)

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Russell W Kerr (M. D. or other)

Address Kans Date signed

(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.....

....., 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 wit the above constitutes grounds for revocation of license.)**

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