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5-17-39  
D-1 X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **6030**  
Registrar's No. **802**

**MAR 21 1941**

Registration District No. **399**

Primary Registration District No. **1002**

118  
23  
8  
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:  
**3536 Woodland**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **12 Yrs.**  
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. **3536 Woodland**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Ralph C. Brown**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Feb.** day **24**  
year **1940** hour **12** minute **45A** M.

3. (b) If veteran, name war **World War** 3. (c) Social Security No. **No.**

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

6. (b) Name of husband or wife **Ruth Brown** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **June 26 1895**  
(Month) (Day) (Year)

8. AGE: Years **45** Months **7** Days **28** If less than one day hr. \_\_\_\_\_ min.

**Bilateral pulmonary tuberculosis**  
Due to **E. carcinoma**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Waiter**

11. Industry or business \_\_\_\_\_

12. Name **James W. Brown**

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

14. Maiden name **Leona Agee**

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

16. (a) Informant **Leona Brown**

(b) Address **3536 Woodland**

17. (a) **Burial** (b) Date thereof **2/26/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah**

18. (a) Signature of funeral director **Mrs C.L. Forster**

(b) Address **918 Brooklyn**

19. (a) **725741** (b) **R. M. Brown**  
(Data received local registrar) (Registrar's signature)

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?  
\_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (Specify means of injury)

23. Signature **R. M. Brown** (M. D. or other)  
Address **K. C. Mo.** Date signed \_\_\_\_\_

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

**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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*J. Calvin Shupert*

Licensed Embalmer No.....

*4179*

P. O. Address.....

*H. E. ...*

**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, fact should be so stated above.**