

Registration District No. 399

Primary Registration District No. 100

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1601 West 9th St. 8
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th
year 1941 hour 6 minute 50 A. M.

21. I hereby certify that I attended the deceased from
4-8-41 19 to 4-9-41 19
that I last saw him alive on 4-9-41 19
and that death occurred on the date and hour stated above.

Immediate cause of death Intercebellar hemorrhage
Coronary occlusion by hemorrhage into
atheromatous plaque

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 8 months of death)

Major findings:
Of operations _____
Of autopsy See above

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) _____
(e) Means of injury _____
23. Signature Walter R. Shaw (M. D. or other) _____
Address Med. Dir. K. C. Gen. Hosp. K. C., Mo. Date signed _____

3. (a) PRINT FULL NAME John Brockwell

3. (b) If veteran, name war world war 3. (c) Social Security No. NO

4. Sex Male 5. Color or race white 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. Aug. (Month) 2 (Day) 1892 (Year)

8. AGE: Years 48 Months 8 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Restaurant man

11. Industry or business _____

12. Name Canellan Brockwell

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

14. Maiden name Kate Atkinson

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

16. (a) Informant Wm. Roger L. Barker

(b) Address 2052 N. 7th, K. C. Kan

17. (a) Burial (b) Date thereof April 11 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Cedarwood R. C. Mo

18. (a) Signature of funeral director Stiles McChase

(b) Address 3235 Sheldon Plaza K. C. Mo

19. (a) Sept 10 1941 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

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

80308

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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.....
....., 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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.