

Registration District No. **399** Primary Registration District No. **1022** Registrar's No. **1648**

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. CONV. Home 3200 Norledge 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **2-yrs**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. **Mo** (b) County. **Jackson 48**
(c) City or town. **Kansas City 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **3200 Norledge 8**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **0** years.

3. (a) PRINT FULL NAME. **ROSE BRANSON**

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

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

6. (b) Name of husband or wife. **Unknown** 6. (c) Age of husband or wife if alive. _____ years

7. Birth date of deceased. **June 1st 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 8 24
hr. _____ min. _____

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

10. Usual occupation. **Home**

11. Industry or business _____

12. Name **Peter Shikles 0**

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

14. Maiden name **No Record**

15. Birthplace **No Record 9** (City, town, or county) (State or foreign country)

16. (a) Informant **Son Wm. Monahan**
(b) Address **3027 East 31st**

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

(c) Place: burial or cremation. **Forest Hill**

18. (a) Signature of funeral director **Edmond J. Wornall**

(b) Address **7406 Wornall**

19. (a) **Apr 26 1941** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **24** 19**41**
year **9** hour **15** minute **P** M.

21. I hereby certify that I attended the deceased from **June 1940**, 19____, to **April 24**, 19**41**
that I last saw her alive on **April 24**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death. _____

Coronary Occlusion

Due to _____

Due to _____

Right Bundle Branch Block Hypertension

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? _____ (e) Means of injury _____

23. Signature **M. M. Brown** (M. D. or Nurse) _____

Address **3200 Norledge** Date **4/25/41**

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

MOTHER FATHER

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 _____

Handwritten signature

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Handwritten signature

Licensed Embalmer No. 2810

P. O. Address H. G. 2nd

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1648

PLACE OF DEATH:

- (a) County
- (b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
R.C. Conn Home 3200 Norledge
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution.....
(Specify whether
- In this community.....
years, months or days)

- 3. (a) PRINT FULL NAME Rose Branson
- 3. (b) If veteran, name war.....
- 3. (c) Social Security No.....

- 4. Sex Female 5. Color or race White
- 6. (a) Single, widowed, married, divorced.....
- 6. (b) Name of husband or wife.....
- 6. (c) Age of husband, or wife, if alive..... year
- 7. Birth date of deceased.....
(Month) (Day) (Year)

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

- 9. Birthplace.....
(City, town, or county) (State or foreign country)
- 10. Usual occupation.....
- 11. Industry or business.....
- MOTHER FATHER { 12. Name.....
- 13. Birthplace.....
(City, town, or county) (State or foreign country)
- 14. Maiden name.....
- 15. Birthplace.....
(City, town, or county) (State or foreign country)

- 16. (a) Informant.....
- (b) Address.....
- 17. (a) (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
- (c) Place: burial or cremation.....
- 18. (a) Signature of funeral director.....
- (b) Address.....
- 19. (a) 4/26/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
- (c) City or town.....
(If outside city or town limits write "RURAL")
- (d) Street No.....
(If rural, give location)
- (e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month April day 24th
year 1941 hour..... minute..... M.
- 21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.
- Immediate cause of death: Coronary Occlusion

- Due to.....
- Due to.....
- Other conditions: hemiplegia 94
(include pregnancy within 3 months of death)
- Major findings: a cerebral hemorrhage probably preceded the hemiplegia
- 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..... (M. D. or other).....
- Address..... Date signed.....

SUPPLEMENTARY

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

HOWARD MOORE

S-13667