S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29355

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3438

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: Ambassador Hotel, 36th & Broadway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Massachusetts (b) County: Plymouth
(c) City or town: Brockton
(If outside city or town limits, write "RURAL")
(d) Street No.: 181 Nilsson Street
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: 48 3 8

3. (a) PRINT FULL NAME: Charles P. Brooks
3. (b) If veteran, name war: World War I
3. (c) Social Security No. 013-09-5837
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Arlene Stanhope Brooks
6. (c) Age of husband or wife if alive: Dec years
7. Birth date of deceased: March (Month) 9 (Day) 1892 (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 17 year 42 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from Coma, 19..., to ..., 19...; that I last saw him alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coma, uremic, cerebral	
Due to: Chronic Nephritis, hypertrophic	
Due to: Arteriosclerosis, hypertensive	
Due to: 93 B	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See above	

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

8. AGE: Years 50 (58) Months 4 Days 8 If less than one day ..... hr. ..... min.
9. Birthplace: Boston (City, town, or county) Massachusetts (State or foreign country)
10. Usual occupation: Printer - Mgr
11. Industry or business:
12. Name (Father): Charles Brooks
13. Birthplace (Father): Boston (City, town, or county) Mass. (State or foreign country)
14. Maiden name (Mother): A.H. Kausel
15. Birthplace (Mother): Boston (City, town, or county) Mass. (State or foreign country)
16. (a) Informant: Dr. John W. Corbett
(b) Address: Brockton, Massachusetts
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-19-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Brockton Mass.
18. (a) Signature of funeral director: Harlan Fox
(b) Address: 7406 Wornall Road, K.C. Mo.
19. (a) 9/19/42 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

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: Corbett (M.D. or other)
Address: Date signed 9/18/42

(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 Harlyn Roe, Registered Apprentice No. ....., working under my personal supervision.

Signed Harlyn Roe

Licensed Embalmer No. 2810

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, fact should be so stated above.