

S. No. 2  
M-9-4-41  
Rev. 5-17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39584

State File No. ....

FILED JAN 11, 1949

Registration District No. 177

Primary Registration District No. 100

Registrar's No. 4905

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. Mary's Hospital.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-12-18-42-12-30-42  
(Specify whether years, months or days)

In this community 1 Month.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 6724 Cherry St.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME William W. BROWN.

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 070-07-4021

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30th  
year 1942 hour 8 minute 25 A. M.

4. Sex Male

5. Color or Race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Evelyn M. Brown

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased February 10th, 1892  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-18-42 to 12-29-42

that I last saw him alive on 12-29-42 1942

and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>10</u>	<u>20</u>	hr. min.

Immediate cause of death myocardial Failure Duration

Due to Bronchial Pneumonia

Due to Staphylococcus Bacillus

Other conditions 107

(Include pregnancy within 3 months of death)

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

10. Usual occupation Reg. Mgr. Standard Brands Inc.

11. Industry or business Wholesale Merc.

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy yes

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name William Ward Brown

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

14. Maiden name Margaret Cambrom.

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

16. (a) Informant Mrs. Evelyn M. Brown.

(b) Address 6724 Cherry St.

17. (a) Removal (b) Date thereof 12/30/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo New York.

18. (a) Signature of funeral director Melody-McGilley

(b) Address K. C. Mo.

19. (a) Dec 30 1942 (b) M. M. Crowe  
(Date received local registrar) (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. St. Sparks (M. D. or other)

Address 1400 Oak St. Date signed 12-30-42

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

**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.....

*J. R. [Signature]*  
.....  
Licensed Embalmer No. **2989**

P. O. Address.....  
**KC**

**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.**