

S. No. 2
DM-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27252

State File No.

3449

FILED AUG 21 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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:
Trinity Lutheran Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days, (Specify whether
In this community unknown 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. 5023 Grand Avenue,
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Lou E. Brightwell,

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

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

6. (b) Name of husband or wife Robert T. Brightwell 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased unknown
(Month) (Day) (Year)

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

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

10. Usual occupation at home,

11. Industry or business X

MOTHER FATHER

12. Name unknown

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

14. Maiden name 9

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

16. (a) Informant Robert T. Brightwell,

(b) Address 5023 Grand Ave., Kansas City, Mo.

17. (a) Burial (b) Date thereof 8-11-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-10-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year 1943 hour minute P. M.

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 (1) Arteriosclerotic Cardiovascular Disease Duration
(2) Inadequate coronary circulation

Due to (3) Cardiac hypertrophy

Due to _____

Other conditions 93d
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy as 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? ✓

While at work? ✓ (Specify type of place) (2) Means of injury

23. Signature Gerald B. Pees (M. D. or other)
Address Trinity Hospital Date signed 8-9-43

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

Dr. Case

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..... *E. M. Plant*

Licensed Embalmer No. *1848*

P. O. Address..... *T. 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.