

FILED OCT 13 1943

149

Registration District No.

Primary Registration District No.

1002

4124

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9/22/43 9/23/43
(Specify whether
In this community Do not know
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 510 Main St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Brown

3. (b) If veteran, name war Do not know 3. (c) Social Security Do not know

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Do not know

6. (b) Name of husband or wife Do not know 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Do not know
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business

MOTHER FATHER { 12. Name Do not know
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Do not know
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Coroner Office

(b) Address Kansas City Mo.

17. (a) School (b) Date thereof Sept. 27 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K. C. College of Osteopathy

18. (a) Signature of funeral director Passantino Bros

(b) Address Kansas City Mo.

19. (a) 9-29-43 (b) J. E. Brown Rep
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23
year 1943 hour 5 minute 55 pm

21. I hereby certify that I attended the deceased from _____
_____ 19____
_____ 19____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy hypertrophic

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? _____

While at work _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (If other) _____
Address [Address] Date signed [Date]

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

301

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 Paul G. Rowe

Licensed Embalmer No. 2347

P. O. Address. K. E. 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.