

FILED DEC 22 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40853

State File No. 4597

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kaw Two Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Home 11910 W Walrond
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 years
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. 1910 Walrond 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sally A. Brinckenfield

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Charles Brinckenfield 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Dec. 12th, 1855
(Month) (Day) (Year)

8. AGE: Years 88 87 Months 11 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robert Black

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Charles Hinckle

(b) Address 1910 Walrond

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/43 (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 E. 15th St

19. (a) 11-22-43 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26 year 1943 hour 2 minute 07 P.M.

21. I hereby certify that I attended the deceased from _____ 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 Arteriosclerotic heart disease

Due to _____

Due to 938

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations _____

Of autopsy respiration & hearing

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)

(c) Means of injury _____

23. Signature [Signature] 3 _____

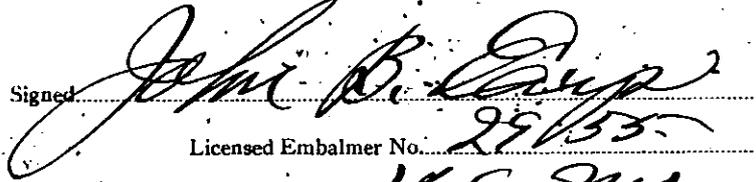
Address _____ Date signed 11/28/43

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

MOTHER FATHER

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..... 
Licensed Embalmer No. 29135
P. O. Address 1111 9th

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.