

FILED MAY 11 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1900

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: Kansas City T.B. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos 25 days
(Specify whether
In this community 19 years
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. 1531 East 11th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME EVA MAE BROWN

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

4. Sex Fe 5. Color or race 3 C 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased. 10 22 23
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 1 18 hr. min.

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

10. Usual occupation Bus girl

11. Industry or business.....

MOTHER FATHER
12. Name Arthur Brown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Mable Tate
15. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records of K.C. TB Hosp.

(b) Address.....
17. (a) Residual (b) Date thereof 12/20/43
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Johnson - Williams
(b) Address 1513 Locust

19. (a) 5-2-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 10
year 43 hour 5:55 minute A.M.

21. I hereby certify that I attended the deceased from July 15
1943 to Dec 10 1943
that I last saw h.e.r. alive on December 10 1943
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Pulmonary Tuberculosis Duration 5 mos

Due to.....

Due to.....

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

Major findings:
Of operations.....
Of autopsy.....

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)

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 Matthew J. Noon (M. D. or other)

Address K.C. TB Hosp. Date signed 4/28/44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.