

FILED APR 20 1944

State File No. ....

Registration District No. 446

Primary Registration District No. 5568

Registrar's No. 62

1. PLACE OF DEATH: **Jackson**

(a) County **Jackson**

(b) City or town ~~Kansas City, Mo.~~ **Rural**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**8619 Smart Blue Township.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether  
In this community **28 years** (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. **8619 Smart Blue Township.**  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Mrs. Mary A. Brown**

3. (b) If veteran, name war **--**

3. (c) Social Security No. **None**

4. Sex **F** / 5. Color or race **W**

6. (a) Single, widowed, married, divorced. **Widowed**

6. (b) Name of husband or wife **James Wm. Brown**

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

7. Birth date of deceased **Aug. 31, 1855**  
(Month) (Day) (Year)

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

88	6	18	hr. .... min.
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9. Birthplace **Belton Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Homemaker**

11. Industry or business **at Home**

MOTHER FATHER { 12. Name **Patriok Mullen**

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

14. Maiden name **Elizabeth Sanford**

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

16. (a) Informant **Mrs. Albert Burriss**

(b) Address **8619 Smart, K.C. Mo.**

17. (a) **Burial** (b) Date thereof **Mar. 22-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Belton, Mo.**

18. (a) Signature of funeral director **Sheil Funeral Home**

(b) Address **K.C. Mo.**

19. (a) **3-21-1944** (b) **James W. Ross**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **19**  
year **1944** hour **10** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **1939**  
**to 3/18/44**, 19.....;  
that I last saw him alive on **3/18/44**, 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**  
**Uremia**

Due to.....

Due to.....

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

Major findings:  
Of operations **none**

Of autopsy.....

Duration **2-3 hrs**

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 **J.P. Miller** (M. D. or N. D.)  
Address **K.C. Mo.** Date signed **3/21/44**

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

Dr. L. E. Riller,  
9715 E 16th St  
CI 4493

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**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.**

Registration District No. *146*

Primary Registration District No. *5568*

Registrar's No. *620*

1. PLACE OF DEATH:

(a) County *Jackson*  
(b) City or town *Rural Township*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME *Mary A. Brown*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *F*

5. Color or race *W*

6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife.....

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

7. Birth date of deceased *Aug 31*  
(Month) (Day) (Year)

8. AGE: Years *88* Months *6* Days *11* less than one day min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

(d) Street No..... (If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* 19 *1944* year. hour..... minute..... M.

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

Immediate cause of death *Senility uremia*

Due to *Uremia due to hypertension & chronic nephritis*

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

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other).....

Address..... Date signed.....

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

MOTHER, FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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