

FILED AUG 2 1944
199

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23606

State File No.

Registration District No.

Primary Registration District No. 1002

Registrar's No.

3009

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether
In this community unk.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town K.C. Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 3415 E 14 St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country D

3. (a) PRINT FULL NAME

Della Brooks

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1944 hour 8 minute 30 P.M.

3. (b) If veteran, name war no

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 M
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Jan 16 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 13, 1944, to July 20, 1944
and that I last saw her alive on July 20, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration

8. AGE: Years 83 Months 8 Days 6 If less than one day hr. min

Due to

9. Birthplace La Fort, Ind (City, town, or county) Ind (State or foreign country)

Due to

10. Usual occupation at home

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

MOTHER FATHER
12. Name R. F. Henry
13. Birthplace unk (City, town, or county) Ind (State or foreign country)
14. Maiden name unk
15. Birthplace Kentucky (City, town, or county) Ind (State or foreign country)

Major findings:

Of operations

Of autopsy

See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Frank Whitehead
(b) Address 3415 E 14 St
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 14 1944
(Month) (Day) (Year)
(c) Place: burial or cremation Medical Center

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?

18. (a) Signature of funeral director D. E. Med...
(b) Address 1401 Bush Creek Blvd
19. (a) Jan 21 44 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

While at work (Specify type of place) (c) Means of injury
23. Signature A. E. Upsher (M. D. or other) MO
Address Med. Dir. Gen'l Hosp. Date signed 7-21-44

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 *R. C. Newcomer*
Licensed Embalmer No. *4043*
P. O. Address *R. C. No.*

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.