

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 9 1944

149

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1002

Registrar's No. \_\_\_\_\_

3041

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:  
Lakeside Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)  
 In this community 25 years

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. 6230 East 15th Street  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country no

3. (a) PRINT FULL NAME Mrs Inas M. Brown  
 3. (b) If veteran, name war no 3. (c) Social Security No. no

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

6. (b) Name of husband or wife Walter Brown 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Nov 1st 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
58 8 21 hr. min.

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

10. Usual occupation Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Samuel Gum  
 13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
 14. Maiden name Davenport  
 15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Alyce Brown  
 (b) Address 6230 East 15th St

17. (a) Burial (b) Date thereof 7th 24th 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt Washington Cem

18. (a) Signature of funeral director Eylar Funeral Home  
 (b) Address 1800 Linwood

19. (a) 7-24-44 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22  
 year 1944 hour 12:00 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 18  
1944 to July 22 1944  
 that I last saw him alive on July 22 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma and renal failure

Due to Acute parenchymatous nephritis following

Due to arteriosclerosis for uterine carcinoma

Other conditions 48h  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of uterus  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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?  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Chas. Curry (M.D. or other) Dr.  
 Address Chambers Bldg Date signed 7-22-44

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

Dr Chas Curry  
Chambers Bg  
12th & Walnut

**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 *Chas E. Wilks*

Licensed Embalmer No. *2644*

P. O. Address. *1800 Pinewood*

**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.**