

No. 2
DM-5-43
v. 5-17-39
I X36671

FILED DEC 22 1944
Registration District No. **199**

Primary Registration District No. **1002**

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

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:
2420 Spruce
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether)

In this community 40 years
years, months or days

3. (a) PRINT FULL NAME Charles M. Brown

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cora M. Brown

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Sept 11th 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>3</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Retired Post Office Clerk

11. Industry or business

12. Name Joseph Brown

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

14. Maiden name Susan Wilson

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

16. (a) Informant Mrs Cora M. Brown

(b) Address 2420 Spruce

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Dec. 15, 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

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

(b) Address Kansas City Mo

19. (a) 12-14-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

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. 2420 Spruce
(If rural, give location)

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

If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13th
year 1944 hour 5 minute A M.

21. I hereby certify that I attended the deceased from 11/20 1944 to 12/12 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cornary Occlusion 3 1/2 hr

Due to Arterio Sclerosis 8 yrs

Due to _____

Other conditions (include pregnancy within 3 months of death) 94 a

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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? _____

23. Signature R. Williams, M.D. (M.D. or other)
Address 5400 S. John St Date signed 12-14-44

Dr Rqbt Williams
5400 St John
Ba 2659

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. 4063

P. O. Address 1800 Lenwood Blvd.

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.