

FILED FEB 17 1945

State File No. _____
 Registrar's No. **564**

Registration District No. **179**

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: **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 **4 days**
(Specify whether years, months or days)
 In this community **unknown**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson** **48**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **312 E. 12 St.**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Frank M. Brown**

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

4. Sex **Male** 5. Color or race **wh** 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 _____
(Month) (Day) (Year)

8. AGE: **off** Years Months Days If less than one day
61 hr. min.

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

10. Usual occupation _____

11. Industry or business **Reborn**

12. Name **unknown**

13. Birthplace _____ 4
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

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

16. (a) Informant **Grand off**
 (b) Address **K E Sun Hoop**

17. (a) **Reborn** (b) Date thereof **2/6/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chicago Ill**

18. (a) Signature of funeral director **Frank Murphy**

(b) Address **2312 Lenwood**

19. (a) **2-5-45** (b) **T. E. Brown (102)**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** Day **4**
 year **1945** hour **5** minute **40** A. M.

21. I hereby certify that I attended the deceased from **January 31**, 19**45**, to **February 4**, 19**45**;
 that I last saw him alive on **February 4**, 19**45**,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure** Duration

Due to **Hypertensive heart disease**

Due to _____

Other conditions **93 d.**
(Include pregnancy within 3 months of death)

Major findings: **93 d.**
 Of operations _____

Of autopsy **None** **PHYSICIAN**

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)
 (e) Means of injury **0**

23. Signature **Clark W. Seely MD**
 Address **Med. Dir. Gen'l Hosp** (M. D. or other) **2-5-45**
 Date signed _____

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..... *Ray E Snow*

Licensed Embalmer No. *2560*

P. O. Address..... *RE M*

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.