

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

**FILED** OCT 23 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4201

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

1. PLACE OF DEATH: **Jackson**

(a) County Kansas City, Missouri  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 7/27/45 - 10/9/45  
(Specify whether \_\_\_\_\_)

In this community. 16 years  
years, months or days

3. (a) PRINT FULL NAME: Sarah Mary Brooks

3. (b) If veteran, name war. None

3. (c) Social Security No. Not known

4. Sex: Female

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Widow

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

6. (c) Age of husband or wife if alive: 9 1867 years

7. Birth date of deceased: June 9  
(Month) (Day) (Year)

8. AGE: 78 Years 4 Months 0 Days  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: North Carolina  
(City, town, or county) (State or foreign country)

10. Usual occupation: unemployed

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

12. Name: John Brooks

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

14. Maiden name: Sophronia

15. Birthplace: Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant: Gerane Brooks

(b) Address: 718 E. 17th

17. (a) Burial (b) Date thereof: 10-15-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Engleland

18. (a) Signature of funeral director: W. J. Green

(b) Address: K.C.

19. (a) 10-12-45 (b) St. Pauline Holmes  
(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.: 718 E. 17th Street  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9th  
year 1945 hour 2 minute 20 A.M.

21. I hereby certify that I attended the deceased from July 27,  
1945 to October 9, 1945  
that I last saw her or alive on October 9, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Decompensation

Due to: Arterio Sclerotic Type Heart Disease

Due to: \_\_\_\_\_

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? \_\_\_\_\_

23. Signature: St. Pauline Holmes (M. D. or other) \_\_\_\_\_  
Address: Gen. Hosp. #2 - Kansas City Date signed: 10/11/45

**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 *John G. Riley*.....

Licensed Embalmer No. 4383.....

P. O. Address 1819 E. 15<sup>th</sup> Ken.....

**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.**