

S. No. 2  
M-2-43  
5-17-39  
P 1 X35697

STANDARD CERTIFICATE OF DEATH

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

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

3

FILED JAN 21 1946  
177

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

Primary Registration District No. 1002

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: General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 hours  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 47  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1025 Cherry  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2nd  
year 1946 hour 3 minute 55 A.M.

21. I hereby certify that I attended the deceased from  
Coroner, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
1-2-3<sup>rd</sup> degree Burns  
Due to Face - Chest - arms - Feet

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no  
Mortality & Inspection  
1952

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) Don't know  
(b) Date of occurrence 1-1-46 123  
(c) Where did injury occur? K.C. Jackson mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In home

While at work? no (Specify type of place)  
(e) Means of injury Burns  
23. Signature Jean O'Fallon (M. D. or other)  
Address 1424 Prof. Rd Date signed 1-2-46

3. (a) PRINT FULL NAME Bernard E. BRINK

3. (b) If veteran, name war World War # 2 3. (c) Social Security No. 487-01-7223

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

6. (b) Name of husband or wife Rose Brink 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased March 29, 1915  
(Month) (Day) (Year)

8. AGE: Years 30 Months 9 Days 3  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Employee

11. Industry or business American Rwy. Express Co.

12. Name Fred H. Brink

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

14. Maiden name Mabel Williams

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

16. (a) Informant Mr. Fred H. Brink

(b) Address 5643 Bales, K.C. Mo.

17. (a) Burial (b) Date thereof 1-4-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Mellody-McGilley-Eylar

(b) Address 1800 Linwood Blvd, K.C. Mo.

19. (a) 1-2-46 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

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

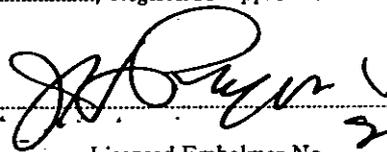
MOTHER FATHER

JAN 27 1946

**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.....

2999

P. O. Address.....



**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.**