

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

State File No. 15

Registration District No. 150

Primary Registration District No. 5577

Registrar's No. J.P.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Little Blue, Rural Precinct
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
County Home for Aged 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mth - 6 da.
(Specify whether years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Miss. (b) County Jackson

(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 15 East 6th St.
(If rural, give location)

(e) Citizen of foreign country? No
If yes, name country _____

3. (a) PRINT FULL NAME Frank Brown

3. (b) If veteran, name war ←

3. (c) Social Security No. ←

4. Sex m 5. Color or race w

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 ? 1889
(Month) (Day) (Year)

8. AGE: Years 57 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation labour

11. Industry or business Unknown

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant County Home Records

(b) Address Independence, Mo RR 4

17. (a) Burial (b) Date thereof 3-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pais Summit

18. (a) Signature of funeral director N B Langeford

(b) Address Pais Summit Mo

19. (a) 3/11/46 (b) Charles Perkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1946 hour 5:40 minute A.M.

21. I hereby certify that I attended the deceased from 2-4-46, 1946 to 3-9, 1946
that I last saw him alive on 3/8, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral regurgitation

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 92k

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J W Greene (M. D. or other) _____
Address Independence Mo Date signed 3/10/46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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..... *W. B. Langford*

Licensed Embalmer No..... *3833*

P. O. Address..... *1000 Diamond*

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.