

S. No. 2
M-5-43
5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36907**
Registration District No. **149**
Primary Registration District No. **1002**
Registrar's No. **4614**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1414 West 39th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50Yrs.** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City, Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **1414 West 39th St**
(If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country **Switzerland**

3. (a) PRINT FULL NAME **Mrs Adrienne Cohn**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **Fe** 5. Color or race **Wh**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **unknown**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 2nd 1866**
(Month) (Day) (Year)

8. AGE: Years Months Days **9** If less than one day
79 10 29 hr. min.

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

10. Usual occupation **At home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Meier Brandenburger**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Julie Picard**
15. Birthplace **France**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ralph Brandenburger**
(b) Address **1414 West 39th St**

17. (a) **Burial** (b) Date thereof **Nov, 4th, 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Cem**
Carroll-Davidson

18. (a) Signature of funeral director _____
(b) Address **3024 Troost Ave**

19. (a) **11-2-46** (b) **Steraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **1st**
year **1946** hour **5** minute **30** P. M.
21. I hereby certify that I attended the deceased from **10-30**
19**46**, to **10-31**, 19**46**.
that I last saw h. **ev.** alive on **10-31**, 19**46**.
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral hemorrhage
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: **830**
Of operations _____
Of autopsy _____

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) _____
(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 **P.M. Nissen** (M. D. or other) _____
Address **1401 SW Blvd** Date signed **11-2-46**

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

35727

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 W. Laybourne.
Licensed Embalmer No. 1715
P. O. Address Kansas City Mo.

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.