

S. No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **994**
Registrar's No. **193**

FILED JAN 27 1947
Registration District No. **779**

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: **Osteopathic Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
21 days (Specify whether years, months or days)
In this community _____

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. **3635 College**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **BERT ELMO BROWN**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **14th**
year **1946** hour **6:** minute **20 P.** M.

4. Sex **Ma**
5. Color or race **Wh**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lulu Brown**
6. (c) Age of husband or wife if alive **56** years
7. Birth date of deceased **November 5 1881**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **12-16** to **1-14** 19**47**.
that I last saw him alive on **1-14** 19**47**.
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
65 **2** **9** hr. min.

Immediate cause of death **Respiratory failure**
Due to **Primary bronchogenic carcinoma**
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: **47c**
Of operations _____
Of autopsy _____

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

10. Usual occupation **Painter**

11. Industry or business _____

MOTHER FATHER
12. Name **Isaac Brown**
13. Birthplace **No Record**
(City, town, or county) (State or foreign country)
14. Maiden name **No Record**
15. Birthplace **II II**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. J.P. Watt**
(b) Address **4547 Indiana**

17. (a) **Removal** (b) Date thereof **1-15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Creston, Iowa**

18. (a) Signature of funeral director **J.W. Wagner**
(b) Address **Kansas City, Mo.**

19. (a) **1-15-47** (b) **Maude Holmes**
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury **D**
23. Signature **J.P. Watt** (M. D. or other) **D.O.**
Address **2903 E. 31st K.C. Mo.** Date signed **1-15-47**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Cecil R. Matthes

Licensed Embalmer No. 3807

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.