

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8931**  
**1156**  
Registrar's No.

**FILED MAR 25, 1947**

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 No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether)

In this community 28 years  
years, months or days

3. (a) PRINT FULL NAME Walter Brandenburg

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Brandenburg

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased August 11 1871  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>7</u>	<u>1</u>	hr. _____ min.

9. Birthplace Fredericksburg, Va.  
(City, town, or county) (State or foreign country)

10. Usual occupation Lecturer & Writer

11. Industry or business Salesman for Bibles

12. Name Ezra Brandenburg

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

14. Maiden name Margaret Wenner

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

16. (a) Informant Mrs. Sarah Brandenburg

(b) Address 2745 1/2 Indiana K. C. Mo

17. (a) Burial (b) Date thereof Mar 15, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Wilks Funeral Home

(b) Address 2315 Lincolnwood K. C. 3 Mo

19. (a) 3-14-47 (Date received local registrar)  
Sheraldine Holmes (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. 2745 1/2 Indiana  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 12  
year 1947 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from March 5, 1947 to March 12, 1947;  
that I last saw him alive on March 12, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy None

Duration \_\_\_\_\_

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 Tom W. Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 3-13-47

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

MOTHER FATHER

*Dr. Akery*

APR 3 1949

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**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 *Chas E. Wilks*  
Licensed Embalmer No. *2644*  
P. O. Address *H. C. 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.