

FILED APR 28 1947

Registration District No. 149

Primary Registration District No. 1202

Registrar's No. 1771

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: St. Vincent's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 1 day
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Michael E. BROWN

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 single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 17, 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 0 1 hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Donald E. Brown

{ 13. Birthplace Kansas City, Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Agnes Taafe

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

16. (a) Informant Mr. Donald E. Brown

(b) Address 2831 Wabash, K. C., Mo.

17. (a) Burial (b) Date thereof 4-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's Cem.

18. (a) Signature of funeral director Melody-McGilley-Eyler

(b) Address Kansas City, Missouri

19. (a) 4-19-47 Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2831 Wabash 8
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18 year 1947 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from 17 April 1947, to 18 April 1947, that I last saw him alive on 18 April 1947, and that death occurred on the date and hour stated above.

Immediate cause of death:

1 Prematurity 1 day

2 Bronchopneumonia 1 day

Due to _____

Due to _____

Other conditions none 159
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy Prematurity

Bronchopneumonia

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)

Means of injury _____

23. Signature H. E. Cox (M. D. or other) MD

Address 320 9th 47th Date signed 1947 47

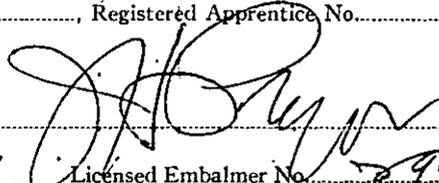
Dr. Cox -
Buehler

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.