

Registration District No. **149** 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: **died On way to General Hospital** **3**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____ (Specify whether years, months or days) **8 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

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

(d) Street No. **2630 East 8th street**
(If rural, give location) **5**

(e) Citizen of foreign country? **no** (Yes or No) **5**
If yes, name country. _____

3. (a) PRINT FULL NAME **Oscar Robert Bruns**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **500-03-2933**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **Anna Rebecca Bruns died 1936**

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

7. Birth date of deceased **April 26 1864**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **25** year **1947** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **2 Jan.** 1946 to **May 15** 1947.
that I last saw him alive on **May 15** 1947 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
83	0	29	hr. _____ min. _____

Immediate cause of death **Cerebral Hemorrhage**

Due to _____

Due to _____

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

10. Usual occupation **Retired cabinet maker**

Other conditions (Include pregnancy within 3 months of death) **83w**

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name **unknown** **0**

13. Birthplace **"** **1**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Walter C. Bruns**

(b) Address **3918 Bellefontaine**

17. (a) **Burial** (b) Date thereof **May 27-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial **Mount Moriah Cemetery**

18. (a) Signature of funeral director **Mrs. C.L. Forster**

(b) Address **918 Brooklyn ave.**

19. (a) **5-27-47** **Steraldine 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? **3**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Lloyd R. Charney** (M. D. or other) **DR.**
Address **5326 E 24th** Date signed **5/23/47**

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..... *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address *718 Brooklyn*
K. 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.