

FILED JUL 19 1947

Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 24107

Registrar's No. 2912

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:  
Wheatley 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

3. (a) PRINT FULL NAME Merle Curran Brooks

3. (b) If veteran, name war no  
 3. (c) Social Security No. none

4. Sex Male  
 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced single  
 6. (c) Age of husband or wife if alive years  
 7. Birth date of deceased OCT. 27, 1946  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
INFANT 78 20 hr. min.

9. Birthplace Independence Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation infant None

11. Industry or business None

12. Name ARTHUR BROOKS

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

14. Maiden name Bessie Wallace

15. Birthplace KANSAS CITY, Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant ARTHUR BROOKS

(b) Address 418 N. Noland Rd.

17. (a) Burial (b) Date thereof July 9, 1947  
 (Burial, cremation, removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wendland Cem. Wash.

18. (a) Signature of funeral director Tele. Dir.

(b) Address 1513 Troost Ave.

19. (a) 7-9-47 (b) Gertrude Holmes  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town INDEPENDENCE  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 418 N. Noland Rd.  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
 year 47 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Acute Gastro-Enteritis Duration \_\_\_\_\_

Due to Dianhea 4

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

Other conditions (Include pregnancy within 3 months of death) 5

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

Of autopsy 1190

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 Eugene D. Chaturon M.D. or other \_\_\_\_\_  
 Address 2202 1/2 S. 18th St. Date signed 7-8-47

**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 *C. C. Davis*

Licensed Embalmer No. 4417

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.**