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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 7 1948
Registration District No. 949

Primary Registration District No. 1002

Registrar's No. 412

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: VINEYARD PARK HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 1/2 MONTHS
(Specify whether)

In this community 34 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 41

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

(d) Street No. 2537 HARRISON STREET
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM MORGAN BROBECK

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 27th
year 1948 hour 8 minute 05 P. M.

21. I hereby certify that I attended the deceased from Oct 13 1947 to Jan 27 1948
that I last saw him alive on Jan 27 1948
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. THERESA BROBECK

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Nov - 5 - 1893
(Month) (Day) (Year)

Immediate cause of death Post-nobis pneumonia Duration 2 day

8. AGE: Years 54 Months 2 Days 22 If less than one day
hr. min.

Due to Osteogenic sarcoma with metastases 3 mo

9. Birthplace COLUMBUS OHIO
(City, town, or county) (State or foreign country)

10. Usual occupation CAFE OPERATOR

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business BROBECKS CAFE

Major findings: Of operations 55 PHYSICIAN

12. Name WILLIAM M. BROBECK

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

14. Maiden name UNKNOWN

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

16. (a) Informant MRS. THERESA BROBECK

(b) Address 2537 HARRISON STREET

17. (a) BURIAL (b) Date thereof JAN. 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director W. H. Newman, Sec'y

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 1-30-48 (b) Alfredine Holmer
(Date received local registrar) (Registrar's signature)

Of autopsy

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 MD

23. Signature DM Morgan (M. D. or other) MD

Address 925 Appleby Date signed 1/28/48

925 W. Myrtle Blvd.
11-5:30pm

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 *D. D. Nofsinger*
Licensed Embalmer No. *5958*
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.