

No. 2
-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **991**
Registrar's No. **413**

FILED FEB 7 1948
Registration District No. **149**

Primary Registration District No. **1002**

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: **GENERAL HOSPITAL NO. 2**
(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 **40 YRS.**

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. **921 CHARLOTTE**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **BURT BROOKS**

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month **JANUARY** day **22**, year **1948** hour **7:** minute **05 A.** M.

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**

21. I hereby certify that I attended the deceased from **JANUARY 21**, 19 **48** to **JANUARY 22**, 19 **48**; that I last saw him **IM** alive on **JANUARY 22**, 19 **48**; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **DECEMBER 12, 1878**
(Month) (Day) (Year)

Immediate cause of death **BRONCHO-GENIC CARCINOMA (X-RAY ONLY)** Duration _____

8. AGE: Years **69** Months **1** Days **10** If less than one day _____ hr. _____ min.

Due to _____

9. Birthplace **WARRENSBURG MISSOURI**
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation **LABORER**

Other conditions (Include pregnancy within 3 months of death) **47C**

11. Industry or business _____

Major findings: Of operations _____

MOTHER FATHER } 12. Name **BURT BROOKS SR.**
13. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

Of autopsy _____

14. Maiden name **FANNIE FREDERICK**
15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant **FRANK WILSON (FRIEND)**
(b) Address **1007 TRACY**

(a) Accident, suicide, or homicide (specify) _____

17. (a) **Removal** (b) Date thereof **1-30-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation **W.C. College of Osteopathy**

(c) Where did injury occur? _____ (City or town) (County) (State)

18. (a) Signature of funeral director **Sheldine Holmes**
(b) Address **2304 4th**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place) (e) Cause of injury _____

19. (a) **1-30-48** (b) **Sheldine Holmes**
(Date received local registrar) (Registrar's signature)

23. Signature **Sheldine Holmes** (M. D. or other) **M.D.**
Address **GENERAL HOSPITAL NO. 2** Date signed **1/23/48**

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 *B. L. Graham*

Licensed Embalmer No. *2540*

P. O. Address *2304 Vine*

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.