

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 29 1948 / 49

State File No. _____
Registrar's No. 5039

Registration District No. _____

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: Lake Side Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community 26 yrs
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Dorie - Brannock
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Fe! 5. Color or race w
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Newton R. Brannock 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased July 7 - 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 5 2 _____ hr. _____ min.

9. Birthplace Indiana!
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name David Mauck

13. Birthplace Ky - 1
(City, town, county) (State or foreign country)

14. Maiden name Sarah Rand

15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Newton Brannock

(b) Address 916 East 8 St

17. (a) Burial (b) Date thereof Dec-11-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director Mr. C. C. Forster

(b) Address 918 Brooklyn

19. (a) 12-10-48 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

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. 916 East 8 St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9
year 19 hour 8 minute 05 P.M.

21. I hereby certify that I attended the deceased from 12-7-48 to 12-9-48, 1948
that I last saw h.p.t. alive on 12-9-48, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary thrombosis
Due to Chronic myocarditis
Due to senility
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
Of operations _____
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? _____

M. L. Fletcher, D.O. (Specify type of place) _____
While at work? _____ (If means of injury)
23. Signature M. L. Fletcher D.O. (Typed or other)
Address 922 W 94 KCMU Date signed 12-9-48

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 Dean Owens

Licensed Embalmer No. 4280

P. O. Address. 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.