S. No. 300
rv. 10-48

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23323
Registrar's No. 3137

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
c. LENGTH OF STAY (In this place): unk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 548 MAIN

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: JACKSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
d. STREET ADDRESS (If rural, give location): 548 MAIN

3. NAME OF DECEASED (Type or Print): a. (First) SAM b. (Middle) W c. (Last) BROWN

4. DATE OF DEATH (Month) 7 (Day) 16 (Year) 49

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown

8. DATE OF BIRTH: _____

9. AGE (In years last birthday): app 68 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: _____

11. BIRTHPLACE (State or foreign country): U

12. CITIZEN OF WHAT COUNTRY?: _____

13a. FATHER'S NAME: _____

13b. MOTHER'S MAIDEN NAME: _____

14. NAME OF HUSBAND OR WIFE: _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): _____ (If yes, give war or dates of service): _____

16. SOCIAL SECURITY NO.: _____

17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Coroner's Office K.C. Mo.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

4201

19a. DATE OF OPERATION: _____

19b. MAJOR FINDINGS OF OPERATION: Deputy Coroner

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): _____

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): _____

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: _____

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: _____

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: A.E. Upsher M.D. — (Degree or title): MD — **23b. ADDRESS**: 2800 Main — **23c. DATE SIGNED**: 7/19/49

24a. BURIAL, CREMATION, REMOVAL (Specify): REM

24b. DATE: 7/21/49

24c. NAME OF CEMETERY OR CREMATORY: KC COLLEGE OF OSTEO

24d. LOCATION (City, town, or county) (State): CITY

DATE REC'D BY LOCAL REG.: 9-20-49

REGISTRAR'S SIGNATURE: Geraldine Holmes

25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: SEBBETOS CITY

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____, Student Embalmer No. _____, working under my personal supervision.

Signed Roy E. Snow

Licensed Embalmer No. 2560

P. O. Address KC Mo

Signed _____
Student Embalmer

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.