

Dept. Health,  
uc., & Welfare  
J. S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44258  
STATE FILE NUMBER  
5735

FILED JAN 8 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5735

V. S. 300.  
Rev. 1-57

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Kansas City</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp</b>   |                                  | Length of stay in 1b<br><b>Life</b>   | d. STREET ADDRESS (If outside, give location)<br><b>8607 Wilson rd</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GERTRUDE</b> Middle <b>M</b> Last <b>BROWN</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>3</b> Year <b>1957</b>  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 7 1908</b>   | 9. AGE (In years (by birthday))<br><b>48</b>         | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City Missouri</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13a. FATHER'S NAME<br><b>Thomas Jefferson Payne</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Ada Myrtle Reed</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Robert A Brown</b> |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>497-34-8406</b>   | 17. INFORMANT Address<br><b>Robert A Brown 8607 Wilson Rd K C Mo</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Virus pneumonia -</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Complicating Surgery for</b><br>DUE TO (c) <b>Repairing ventral hernia -</b> |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>492+</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |                                  |   |  |  |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE            |   |
| 21. I attended the deceased from <b>11-26-57</b> to <b>12/3/57</b> and last saw her alive on <b>12/3-57</b> .<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>E. N. Gentry M.D.</b>  |                                  |   | 22b. ADDRESS<br><b>324 E 11<sup>th</sup> city</b>  |  | 22c. DATE SIGNED<br><b>12/4/57</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>Dec 7 1957</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Washington Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City Missouri</b>                      |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Sheil Funeral Home Kansas City Mo</b>  |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>12-4-57</b>   | 26. REGISTRAR'S SIGNATURE<br><b>neva minshall</b>    |   |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

E. N. Gentry  
 USING ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

1908

Location

Address

Location

Address

X

City

X

X

City

X

City

State

State

X

State

City

City

State

City

City

Robert A Brown

Ada Tuttle Feeley

Thomas J. Brown Payne

Robert A Brown 2607 Wilson Rd K C Mo 487-34-200

No

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.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Thomas A. Lind*

Licensed Embalmer No. *4854*  
P. O. Address *J. C. M. Co.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Print Name and Address of Licensed Embalmer