

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014092

STATE FILE NUMBER

FILED MAY 9 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2049

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1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Mary's Hospital</u> Length of stay in lb <u>25 years</u>		d. STREET ADDRESS (If outside, give location) <u>3520 Baltimore</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>R</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10 1886</u>
9. AGE (In years last birthday) <u>71</u>		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) <u>Customs Shipping Clerk</u>		10b. KIND OF BUSINESS, INDUSTRY, OR SERVICE <u>East Star Emery Bird Thayer</u>	11. BIRTHPLACE (City and state or country) <u>Attica Indiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13a. FATHER'S NAME <u>John Brown</u> 13b. MOTHER'S M maiden name <u>Amilda Murphy</u>	
14. NAME OF HUSBAND OR WIFE <u>Daisy Brown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>470-01-4395</u>		17. INFORMANT <u>Mrs Daisy Brown</u> Address <u>3520 Baltimore</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>WITH PULMONARY EDEMA</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>15 YRS</u> <u>2 DAYS</u> <u>442X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NEPHROSCLEROSIS WITH UREMIA, COMPLETE A-V BLOCK</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Hour _____ Month, Day, Year _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <u>APRIL 19, 1958</u> to <u>APRIL 22, 1958</u> and last saw <u>him</u> alive on <u>APRIL 22, 1958</u> Death occurred at <u>2:45</u> <u>0</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James W. Fowler M.D.</u>		22b. ADDRESS <u>1103 GRAND AVE. KANSAS CITY, MO.</u>	
22c. DATE SIGNED <u>APR 22, 1958</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>April 23 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>Hilke Funeral Home 2315 Sunwood</u>	
25. DATE RECD. BY LOCAL REG. <u>4-22-58</u>		26. REGISTRAR'S SIGNATURE <u>Meva Marshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Never combine, etc. - use only standard nomenclature in Item 18. No symptoms will be listed.

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

Licensed Embalmer No.....

P. O. Address.....

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.