

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014095

STATE FILE NUMBER 1729

FILED APR 23 1958

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

300 0  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hosp.</b>		Length of stay in lb <b>72 Years</b>	d. STREET ADDRESS (If outside, give location) <b>6211 Forest</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SOPHIA</b> Middle <b>E.</b> Last <b>BRUMAGE</b>			4. DATE OF DEATH Month <b>April</b> Day <b>4th</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1885</b>
9. AGE (In years last birthday) <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Euler</b>	
13b. MOTHER'S MAIDEN NAME <b>Caroline Boyson</b>		14. NAME OF HUSBAND OR WIFE <b>Everett W. Brumage</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Everett W. Brumage, 6211 Forest, K.C. Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emphysema &amp; Arteriolitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Status Asthmaticus</b> DUE TO (c) <b>Bronchial Asthma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebrovascular Accident (Thrombosis?)</b> <b>Gastric Hemorrhage</b> <b>Broncho pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b> <b>5 days.</b> <b>30 Years.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>1414</b>		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 <b>1952</b> to <b>4 April 1958</b> and last saw him live on <b>3 April 1958</b> Death occurred at <b>8:15</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Philip G. Kaul M.D.</b>		22b. ADDRESS <b>411 Nichols Rd</b>	22c. DATE SIGNED <b>4 April 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 7, '58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>FREEMAN MORTUARY, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-4-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Philip G. Kaul

MEDICAL CERTIFICATION

PLAIN TIME B.36.  
JE. 1-1226  
1:30-5:00 PM  
FRIDAY

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 *Clayton Barnes* .....

Licensed Embalmer No. 4793 .....  
P. O. Address K. E. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.