

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017095

STATE FILE NUMBER

FILED APR 29 1958

360

6225

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 65

S. 300  
1-57

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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

1. PLACE OF DEATH a. COUNTY <b>VERNON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>Lawrence</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WASHINGTON TOWNSHIP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>AURORA</b> <b>0550</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STATE HOSP #3, MO</b>		Length of stay in lb <b>1945-2 months</b>	d. STREET ADDRESS (If outside, give location) <b>R.F. 1</b>
3. NAME OF DECEASED (Type or print) First <b>VISA</b> Middle <b>MAY</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>APR. 23. 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>56</b>
13a. FATHER'S NAME <b>CHARLES C. COX</b>		13b. MOTHER'S MAIDEN NAME <b>NANCY ANN CLIFTON</b>	11. BIRTHPLACE (City and state or country) <b>ARKANSAS</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>---</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
14. NAME OF HUSBAND OR WIFE <b>W. J. BROWN</b>		17. INFORMANT Address <b>HOSP. RECORDS STATE HOSP #3, MOVA, 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>BRONCHO PNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ATHERO - SCLEROTIC CARDIOVASCULAR DISEASE</b>			<b>MANY YEARS</b>
DUE TO (c) <b>GENERALIZED ARTERIO SCLEROSIS</b>			<b>4221</b> <b>MANY YEARS</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? - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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 checked="" 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>JAN. 11. 1939</b> to <b>APR. 8. 1958</b> and last saw her alive on <b>APR. 8. 1958</b> Death occurred at <b>8:05 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title)		22b. ADDRESS <b>Nevada Mo</b>	22c. DATE SIGNED <b>4-8-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4/9/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
24. FUNERAL DIRECTOR <b>Fulton Funeral Home</b>	ADDRESS <b>N.C. Kansas</b>	25. DATE RECD. BY LOCAL REG. <b>4-22-1958</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

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 *Lloyd C. McCord* .....

Licensed Embalmer No. *4853* .....

P. O. Address *Floyd, 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.