

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030274

Filed VS AUG 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **7425** STATE FILE NUMBER

| | | | | | |
|--|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>St. Louis</i> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <i>St. Louis</i> | | Length of stay in 1b <i>1 hr</i> | c. CITY OR TOWN <i>Kansas City</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <i>Trachet Union Station</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS <i>2104 Vine</i> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>BIRDIE</i> Middle <i>BROWN</i> Last <i>BROWN</i> | | | 4. DATE OF DEATH Month <i>August</i> Day <i>9</i> Year <i>1959</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Negro</i> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 1905</i> | 9. AGE (last birth-day) <i>53</i> | IF UNDER 1 YEAR Months <i>10</i> Days <i>3</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Gen Hospital</i> | | 11. BIRTHPLACE (City and State or country) <i>FAN CITY MO</i> | |
| 12. CITIZEN OF WHAT COUNTRY <i>Johnson</i> | | 13a. FATHER'S NAME <i>George Brown</i> | | 13b. MOTHER'S MAIDEN NAME <i>Annice Laskey</i> | |
| 14. NAME OF HUSBAND OR WIFE <i>Eula Brown</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | | |
| 16. SOCIAL SECURITY NO. <i>497-44-5361</i> | | 17. INFORMANT Address <i>Eula Brown 2104 Vine K.C. Mo</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mitral insufficiency</i> also, <i>Calcification of Rt. Breast</i> and <i>Diabetes Mellitus</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3/31/58</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Treated 7/28/59</i> | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? 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.) <i>None</i> | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | 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 <i>8/9/59</i> to <i>7/28/59</i> and last saw her <i>7/28/59</i> him alive on Death occurred at <i>8/9/59 2:26 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22. SIGNATURE <i>Henry B. Jones M.D.</i> | | | 22b. ADDRESS <i>1605 E. 15th St.</i> | | 22c. DATE SIGNED <i>8/9/59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal 8-9-59</i> | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY <i>K.C. MO.</i> | |
| 24. FUNERAL DIRECTOR <i>E. Sterling Baker</i> | | ADDRESS <i>1212 N.W.</i> | | 25. DATE RECD. BY LOCAL REG. <i>AUG 10 '59</i> | |
| | | | | 26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

E. Steubing B...

Licensed Embalmer No. 3178

P. O. Address 1212 Win

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.