

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 12 1960

5795-60-041891
5795 STATE FILE NUMBER

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

DED

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| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Length of stay in lb <u>12 yrs</u> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>141 No. Joppany</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence ALVIN Brown Jr.</u> | | | 4. DATE OF DEATH Month Day Year <u>11 17 - 1960</u> | |
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|--------------------|-------------------------------|--|-----------------------------------|----------------------------------|--|----------------|
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-7-1948</u> | 9. AGE (last birthday) <u>12</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|--------------------|-------------------------------|--|-----------------------------------|----------------------------------|--|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>school</u> | 11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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|---|---|-----------------------------------|
| 13a. FATHER'S NAME <u>Clarence A. Brown</u> | 13b. MOTHER'S MAIDEN NAME <u>Virginia Goodman</u> | 14. NAME OF HUSBAND OR WIFE _____ |
|---|---|-----------------------------------|

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| 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>none</u> | 17. INFORMANT <u>Virginia Brown</u> Address <u>141 N. Joppany</u> |
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| 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>Pertomitis</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) <u>Ruptured appendix</u> | | |
| DUE TO (c) _____ | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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|---|--|---|
| 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 _____ to _____ and last saw her alive on _____
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) <u>Hugh H. Owens Coroner</u> | 22b. ADDRESS <u>152 Union Station</u> | 22c. DATE SIGNED <u>11-18-60</u> |
|---|---------------------------------------|----------------------------------|

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|---|-----------------------------|---|--|
| 23a. BURIAL CREATION, REMOVAL (specify) <u>Burial</u> | 23b. DATE <u>11-21-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>mt Washington Cem</u> | 23d. LOCATION (city, town, or county) (State) <u>Kansas City, Mo</u> |
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| 24. FUNERAL DIRECTOR <u>C. H. Blackman & Son</u> ADDRESS <u>15-C, Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>11-18-60</u> | 26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Hugh H. Owens

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bert B. B...

Licensed Embalmer No. 4656

P. O. Address H. C. 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.