

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

4758-61-032756  
STATE FILE NUMBER

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

AMENDED

FILED OCT 11 1961

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) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in 1b <b>50 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ALBRATTON NURSING HOME INSTITUTION <b>3001 Woodland Ave.</b>		d. STREET ADDRESS (If outside, give location) <b>1618 Troost Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MOLLIE B. BROWN</b>		4. DATE OF DEATH Month Day Year <b>SEPT 21 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2 16 1885</b>
9. AGE (last birthday) <b>76 yrs</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (City and state or country) <b>Slater Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>William Cavell</b>	
13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>deceased</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>unknown</b>	
17. INFORMANT <b>Fannie Massingale</b>		Address <b>3939 Benton Blvd</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>Cerebral Thromboses</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Brain Damage</b>			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
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>none</b>	
20c. TIME OF INJURY Hour, a.m., p.m. Month, Day, Year <b>none</b>			
20d. INJURY OCCURRED WHILE AT WORK ( ) NOT WHILE AT WORK ( )		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>none</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Kansas City, Jackson, MO</b>
21. I attended the deceased from <b>July 26</b> and last saw <b>him</b> alive on <b>Sept 21, 61</b> Death occurred at <b>9:30</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John H. Wells MD</b>		22b. ADDRESS <b>3718 Prospect</b>	22c. DATE SIGNED <b>9/25/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Sept 25 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City Mo.</b>
24. FUNERAL DIRECTOR <b>C. K. Kerford Funeral Home K. C. Mo.</b>		25. DATE REGD. BY LOCAL REG. <b>9-25-61</b>	26. REGISTRAR'S SIGNATURE <b>Beth Long</b>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

John H. Wells

**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

*C. Kenneth Reynolds*

Licensed Embalmer No.

*4437*

P. O. Address

*Kenner City, 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.