

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5390-61-036799
STATE FILE NUMBER

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

7. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 2 WEEKS	c. CITY OR TOWN Mission Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5711 Sheridan Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First James Middle Lester Last Brown			4. DATE OF DEATH Month 10 Day 27 Year 61			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/24/90	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER & PRESIDENT		10b. KIND OF BUSINESS OR INDUSTRY J. LESTER BROWN REALTY COMPANY		11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.		
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME GEORGE W. BROWN		13b. MOTHER'S MAIDEN NAME JESSIE McELWAIN		
14. NAME OF HUSBAND OR WIFE MAE E. BROWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MAE E. BROWN MISSION, KANSAS				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Infarction, Congestive Heart Failure.		5 Mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Rheumatic Mitral Valoulitis with Insufficiency.	20 Years
DUE TO (c)		

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 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.)	
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 Jan 1959 to 10-27-61 and last saw him alive on 10-27-61
Death occurred at 9:25 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. Petry M.D.	22b. ADDRESS 2015 63d St. Kansas City Mo	22c. DATE SIGNED 10-30-61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 30, '61	23c. NAME OF CEMETERY OF PREPARATION JOHNSON COUNTY MEM. GA.
23d. LOCATION (City, town, or county) JOHNSON COUNTY KANSAS	24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 10-30-61
26. REGISTRAR'S SIGNATURE Ruth Long		

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO.
 SHOULD READ

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

Paul P. Honey

Licensed Embalmer No. 2724

P. O. Address NC 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.