

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024194

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3295 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY <p style="text-align: center; font-size: 1.2em;">Jackson</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b <p style="text-align: center; font-size: 1.2em;">19 Yrs</p>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grosse Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 301 W. Armour Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <p style="text-align: center; font-size: 1.2em;">Emma Brooke</p>			4. DATE OF DEATH June 10 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-6-1887	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) McCool Jct. Nebr. USA	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John J. Hubenbecker		13b. MOTHER'S MAIDEN NAME Dorothea Stein	
13c. NAME OF HUSBAND OR WIFE Carl Brooke		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT Miss Charlotte E. Brooke 301 W. Armour		Address			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>myocardial failure</i>		
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.		
DUE TO (b) <i>Arteriosclerosis - Hypertension</i>		
DUE TO (c) <i>Brain hemorrhage 5 mos ago</i>		<i>immediate</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>5 mos ago massive brain hemorrhage unable to move or speak since</i>		PART III. 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.)
20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. _____		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 Sept 2 1960 to June 10 1963 and saw her alive on April 1 1963
 Death occurred at about 9:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Hester J. Wilson MD</i>	(Degree or title)	22b. ADDRESS <i>411 Nichols Road</i>	22c. DATE SIGNED <i>6/11/63</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-12-63	23c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge	23d. LOCATION (City, town, or county) (State) McCool Junction, Kansas
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24. FUNERAL DIRECTOR Stine & McClure Kansas City, Missouri	25. DATE RECD. BY LOCAL REG. 6-11-63	26. REGISTRAR'S SIGNATURE <i>Ruth N. Long</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ INSTEAD OF
 DATE AMENDED
 1 VS 300 Rev. 4/59
 2 3488
 3
 4 1
 5 2
 6
 7 1
 8 2
 9 331X
 10
 11
 12 86-0
 13
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF Hester J. Wilson

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Steeter Wilson
411 Spradley Rd
Pe 1-2 33
plus 1:30

99
0

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 Behan W Meeker

Licensed Embalmer No. 5078
P. O. Address KC, 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.