MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

OCT 13 1939

31617
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township of Kansas City
(c) City
Registration District No. 395
Primary Registration District No. 100
Registered No. 3715
(d) Street No. 1504 Indiana St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Francis Anchore
(a) Residence, No. 1504 Indiana St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. Male | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~ Kathryn Anchore

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 10-1868

7. AGE Years 71 Months 6 Days 27 If LESS than 1 day, ...hrs. ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Buffet
9. Industry or business in which work was done, as saw mill, bank, etc. Proprietor
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER
13. NAME John Anchore
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

MOTHER
15. MAIDEN NAME Margaret Murphy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Mrs Kathryn Anchore
(ADDRESS) 1504 Indiana

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE 9/13/39

19. FUNERAL DIRECTOR (NAME) J. F. O'Donnell Co.
(ADDRESS) 3956 Broadway

20. FILED Sept 24 1939 M. M. Grove
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 11 1939

22. I HEREBY CERTIFY, That I attended deceased from 8/30 1939 to 9/22 1939
I last saw him alive on 9/21 1939. Death is said to have occurred on the date stated above, at 1:10 a.m.
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis — Date of onset unknown
Causing
Other contributory causes of importance: acute interstitial nephritis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) D. C. Russell M. D.
(Address) 3231 E. 11th St.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PHYSICIANS MUST FILL OUT THIS CERTIFICATE IN INK AND THIS IS A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.