Form 111 16-40

. No. 2
-11-10-39
5-17-39
-I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20908

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2525

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 5 Hrs (Specify whether years, months or days)
In this community: 12 Hrs

3. (a) PRINT FULL NAME: Infant of Chas.& Laura Anders

3. (b) If veteran, name war: ---

3. (c) Social Security No.: ---

4. Sex: Femal

5. Color or race: White

6. (a) Single, widowed, married, divorced: ---

6. (b) Name of husband or wife: —

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: June (Month) 21 (Day) 1940 (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	12 hr. 00 min.

9. Birthplace: Dodson Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation: None --- 0

11. Industry or business: None 0

FATHER
12. Name: Charles F.Anders
13. Birthplace: — (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Laura J Chastine
15. Birthplace: — (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Chas. F.Anders
(b) Address: Dodson Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 22 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Palastine Cem.

18. (a) Signature of funeral director: Mrs C.L.FOrster
(b) Address: 918 Brooklyn Kansas City Mo

19. (a) June 21, 1940 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0

(a) State: Missouri (b) County: Jackson

(c) City or town: Dodson Mo.
(If outside city or town limits, write "RURAL")

(d) Street No.: 83 & Indiana
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1940 hour 7 minute A M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__;
that I last saw h__ alive on ____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	
Due to: Pneumonia	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury: !

23. Signature: Harry M Kelly (M. D. or other)
Address: 1624 Pet Bldg Date signed:

(Licensed Embalmer's Statement on Reverse Side)

Prop Bg

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 Jas. R. Huston

Licensed Embalmer No. 1621

P. O. Address 918 Brooklyn

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

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