S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1941 899

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1002

Primary Registration District No.

State File No. 41539

Registrar's No. 4932

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: Hospital (Specify whether)

In this community: 16 days (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: Kansas City, Mo

(If outside city or town limits, write "RURAL")

(d) Street No.: 8116 Woodland (Rural)

(If rural, give location)

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

3. (a) PRINT FULL NAME: HOMER C. C. ANDERSON (Homer C. Anderson)

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: —

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Victoria Jones Anderson

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

7. Birth date of deceased: Oct. (Month) 23 (Day) 1868 (Year)

8. AGE: Years 72 Months 2 Days 3 If less than one day: ____ hr. ____ min.

9. Birthplace: Ohio (City, town, or county) (State or foreign country)

10. Usual occupation: Retired Carpenter

11. Industry or business: ✓

MOTHER FATHER

12. Name: unknown Anderson

13. Birthplace: Ohio (City, town, or county) (State or foreign country)

14. Maiden name: Chambers

15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant: H. Martha Anderson

(b) Address: 1015 E. 84th Terrace, K.C., Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 28, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Belton, Mo.

18. (a) Signature of funeral director: C. K. Gregory & Sons

(b) Address: Grandview, Mo

19. (a) 12-27-40 (Date received local registrar) (b) M. M. Orowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26 year 1940 hour 7 PM minute ____ M.

21. I hereby certify that I attended the deceased from Dec 12, 1940, to Dec. 26, 1940 that I last saw him alive on Dec. 26, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial failure (chronic)	
Due to: Pulmonary edema	
Due to: Retroperitoneal Abscess	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: Trans-urethr. prostatic Resection Benign Hypertrophy Prostate

Of autopsy: yes

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: [illegible] MD (M. D. or other)

Address: 1019 Prof Bldg Date signed: 12/27/40

(Licensed Embalmer's Statement on Reverse Side)

MAY 25 1948

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 A. K. George

Licensed Embalmer No. 3645

P. O. Address Grandview, 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 this body is not embalmed, above space should be left blank.