S. No. 2
M—1-4-41
v. 5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 10 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24149

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2688

048
3
8

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

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:
General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7-1-41-7-13-41 (Specify whether
In this community 15 years 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Mo. (b) County Jackson

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

(d) Street No. 1918 E. 14th St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Anna Dykes

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 12 (Month) 25 (Day) 1901 (Year)

8. AGE: Years 39 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Dallas (City, town, or county) Texas 1 (State or foreign country)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-41 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director West, Appleton & Jones
(b) Address 1905 Vine St.

19. (a) July 18, 41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 13
year 41 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from 7-1- 1941, to 7-13- 1941;
that I last saw her alive on 7-13- 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Generalized Sarcoma of Rt. Knee	
Due to ~~55B~~	
Due to 55b	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Above Mentioned	

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 [signature] (M. D. or other) D
Address Gen. Hosp. #2 Date signed 7-18-41

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(Licensed Embalmer's Statement on Reverse Side)

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 C. A. West

Licensed Embalmer No. 2710

P. O. Address K. C. 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, fact should be so stated above.