

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33749

Registrar's No. 3680

Registration District No. ....

Primary Registration District No. ....

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:  
Wheatley Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Nine Days  
Ten Days (Specify whether  
In this community.....  
years, months or days) 0

3. (a) PRINT FULL NAME George Anderson

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jessie Anderson 6. (c) Age of husband or wife if alive about 50

7. Birth date of deceased. October 1879  
(Month) (Day) (Year)

8. AGE: Years 62 Months - Days - If less than one day  
hr. min.

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

10. Usual occupation Mecanis Helper Katy R.R.

11. Industry or business M.K. & T.R.R.Co

12. Name Dont Know

13. Birthplace Palestine Texas  
(City, town, or county) (State or foreign country)

14. Maiden name Dont Know

15. Birthplace Dont Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Viazza Anderson

(b) Address 2451 Highland Ave

17. (a) Removal (b) Date thereof 10-3-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Denison Texas

18. (a) Signature of funeral director W. H. Appleton & Jones

(b) Address 1905 Union St

19. (a) Oct 2, 1941 (b) M M Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 049  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2451 Highland Ave  
(If rural, give location) no  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 1st day  
year 1941 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from SEPT. 19, 1941  
19... to OCT. 1, 19...  
that I last saw him alive on OCT. 1, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death  
(2) Myocardial Infarction  
Aorta (Secundary Aneurysm)  
Myocardial Degeneration  
Decompensation

Duration

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 930  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)

23. Signature Royce B. Fleming M. D. or other \_\_\_\_\_  
Address 210 Tenth St. S.W. Date signed 10/3/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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

*C. Hest*

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.**