

13096

State File No.

Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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:
4408 Wornall Road
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution --
 In this community 50 Years
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Miss Anna B. Cole3. (b) If veteran, name war World War I 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years7. Birth date of deceased May 7 1877
(Month) (Day) (Year)8. AGE: Years 65 Months 11 Days 5 If less than one day hr. min.9. Birthplace North Wales 4
(City, town, or county) (State or foreign country)10. Usual occupation Registered Nurse11. Industry or business St. Luke's Hospital12. Name Michael Cole 413. Birthplace N. Wales
(City, town, or county) (State or foreign country)14. Maiden name Budget - 415. Birthplace N. Wales
(City, town, or county) (State or foreign country)16. (a) Informant Deaconess D. Betz(b) Address 4408 Wornall Road17. (a) Burial (b) Date thereof April 14, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial of cremation Newcomer's Vaults18. (a) Signature of funeral director O. N. Newcomer's Son(b) Address 1401 Brush Creek Blvd19. (a) 4-13-43 (b) M. N. Granger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4408 Wornall Road
 (If rural, give location)
 (e) Citizen of foreign country? Yes (Yes or No)
 If yes, name country Wales

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th
year 1943 hour 1 minute 30 A. M.21. I hereby certify that I attended the deceased from an
1943, to 4-12-43, 19...
that I last saw her alive on 4-11-43, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death

Hyper-tensive Cardio-vascular disease

Due to

Due to

Other conditions...
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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) (e) Means of injury

23. Signature H. Wheeler (M. D. or other)
Address 1500 W. 13th St. Bldg Date signed 4-12-43

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

MAY 5 1943

1-3
Spencer

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 *N. C. Newcome*

Licensed Embalmer No. *4043*

P. O. Address *N. C. Ms*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1749

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Anna B. Cole

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

4. Sex..... 5. Color or race..... 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..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) Removal (b) Date thereof 5-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arlington Cem. Washington D.C.

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 4-13-43 (b) M. M. Crowl
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 19 Year 1943 hour 9 minute M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration

PHYSICIAN

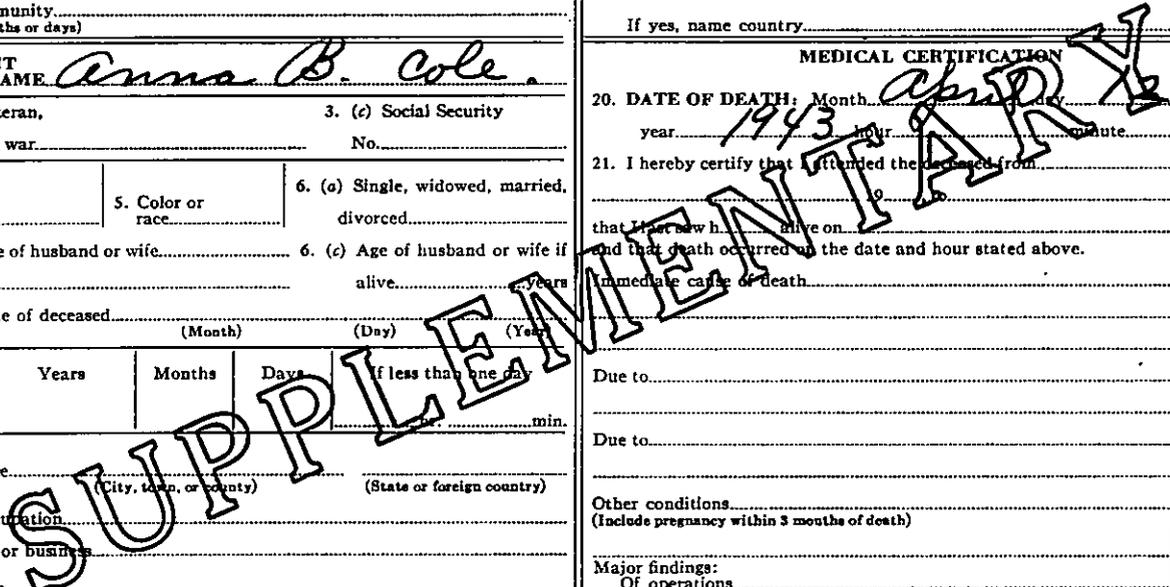
Underline the cause to which death should be charged statistically.

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)
While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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



1309b