

**FILED AUG 14 1943** 149

Registration District No. \_\_\_\_\_

Primary Registration District No. **1002**

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 0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7/6-7/8-43**  
(Specify whether  
In this community **unknown**  
years, months or days)

3. (a) PRINT FULL NAME **ANNA CAVE**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **3 Negro** 6. (a) Single, widowed, married, divorced **9 unknown**  
6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive **unknown** years  
7. Birth date of deceased **unknown**  
(Month) (Day) (Year)

8. AGE: Years **app 50** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **none**

11. Industry or business **unknown**

MOTHER FATHER

12. Name **unknown**  
13. Birthplace **unknown** 9  
(City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown** 9  
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **8-2-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Legeds**

18. (a) Signature of funeral director **Wm C. J. J. J.**

(b) Address **City, Missouri**

19. (a) **8-2-43** (b) **P. E. Brown**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** 48  
(c) City or town **Kansas City** 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. **569 Charlotte--3rd fl.** 8  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**  
year **1943** hour **3:17** minute **P** M.

21. I hereby certify that I attended the deceased from **July 6**, 1943, to **July 8**, 1943;  
that I last saw him alive on **July 8**, 1943;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Cerebral thrombosis** Duration \_\_\_\_\_

Due to **Cerebral Sclerosis**

Due to **83 hr**

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury **0**

23. Signature **P. E. Brown** (M. D. or other) **MA**  
Address **New Hope #2, 600 E. 22nd St** Date signed **7-12-43**

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**