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 3 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41299

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5355

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: K.C.T.B. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 m 1 d. (Specify whether years, months or days)

In this community 18 yrs.

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.: 5414 East 12th St
(If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: Anna Price

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: F

5. Color or race: W

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

6. (b) Name of husband or wife: Arthur Price

6. (c) Age of husband or wife if alive: 46 years

7. Birth date of deceased: 11 (Month) 30 (Day) 1903 (Year)

8. AGE: Years 40 Months 0 Days 15 If less than one day ____ hr. ____ min.

9. Birthplace: Macon (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: John Boron

13. Birthplace: Edina (City, town, or county) Mo. 0 (State or foreign country)

MOTHER 14. Maiden name: Ella Hoggan

15. Birthplace: Atlanta (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant: Records K.C.T.B. Hospital

(b) Address: Leeds Mo.

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof: Dec 18-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Floral Hills

18. (a) Signature of funeral director: Shit Funeral Home

(b) Address: Kansas City Mo

19. (a) 12-17-43 (Date received by local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 15 year 1943 hour 12-15 minute P. M.

21. I hereby certify that I attended the deceased from 10-14-43, 19__, to 12-15, 1943 that I last saw her alive on 12-15, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	10 yrs.
Due to:	
Due to: 12-15	
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Matthew J. Koon (M. D.)

Address: K.C.T.B. Hospital Date signed: 12/15/43

56

(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.....

Licensed Embalmer No. 86 E 5

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.