

V. S. No. 2  
 FORM-8-43  
 Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

FILED JAN 4 1948  
 149

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 10053

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

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

5226

1. PLACE OF DEATH: Jackson  
 (a) County  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3331 Wvandtote  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution XX (Specify whether)  
 In this community Life (Specify whether)  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City 3  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3331 Wvandtote 8  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. ANNA B. CURL  
 3. (b) If veteran, name war XX  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec. day 22d  
 year 1944 hour 7: minute 40 A. M.

4. Sex Fe | 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (c) Age of husband or wife if alive XX years  
 7. Birth date of deceased: December 1 1874  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
 September 5 1944 to Dec 22 1944  
 that I last saw her alive on Dec 22 1944  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Coronary Arteriosclerosis Duration

8. AGE: Years Months Days If less than one day  
 70 0 21 hr. min.

Due to Peritonitis & Sepsis  
 Due to \_\_\_\_\_

9. Birthplace: Kansas City Mo. (D)  
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
 942

10. Usual occupation: At Home  
 11. Industry or business:  
 12. Name: John Barrons,  
 13. Birthplace: Ireland (U)  
 (City, town, or county) (State or foreign country)  
 14. Maiden name: Winifred Grady  
 15. Birthplace: Ireland (U)  
 (City, town, or county) (State or foreign country)

Major findings:  
 Of operations:  
 Of autopsy:  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant: Miss Ann Curl  
 (b) Address: 3331 Wvandtote  
 17. (a) Burial (b) Date thereof: 12-26-1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation: Calvary Cemetery  
 18. (a) Signature of funeral director: J. W. Wagner  
 (b) Address: Kansas City, Mo.  
 19. (a) 12-23-44 (b) T. E. Brown (U) (Registrier's signature)  
 (Date received local registrar)

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: Frank J. [Signature] (M. D. or other)  
 Address: 315 [Address] Date signed: 12-22-44

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

MOTHER FATHER

H. W. P. J. Bridge M.D.  
315 Alameda Rd.  
Wichita

Wichita

**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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.**