

FILED FEB 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

944

Registration District No. _____

149

Primary Registration District No. _____

1002

Registrar's No. _____

425

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:
RESEARCH HOSPITAL.
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 10 DAYS
 (Specify whether
 In this community 10 DAYS
 years, months or days) _____

3. (a) PRINT FULL NAME MRS LILLIE A BENE ANDRESON

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

4. Sex FEMALE 5. Color or race WHITE6. (a) Single, widowed, married, divorced WIDOWED
 (b) Name of husband or wife PAUL D. ANDRESON
 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased DEC. 29 - 1889
 (Month) (Day) (Year)8. AGE: Years 55 Months 0 Days 27
 If less than one day _____ hr. _____ min.9. Birthplace SYLVAN GROVE, KANSAS
 (City, town, or county) (State or foreign country)10. Usual occupation HOUSE WIFE11. Industry or business AT HOME12. Name ALYNSON R BUZICK13. Birthplace DES MOINES, IOWA
 (City, town, or county) (State or foreign country)14. Maiden name MARY E McADAMS15. Birthplace TRIO, BRICK, KANSAS
 (City, town, or county) (State or foreign country)16. (a) Informant A R Buzick(b) Address Sylvan Grove, Mo.17. (a) 1308 1/2 (b) Date thereof 1-27-45
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sylvan Grove, Mo.18. (a) Signature of funeral director D W Newcomes(b) Address 1401 Birch Creek Blvd.19. (a) 1-27-45 (b) P. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State KANSAS (b) County Linn
 (c) City or town SYLVAN GROVE.
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? 2. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 26th day January
 year 1945 hour 5 minute _____ P.M.21. I hereby certify that I attended the deceased from January 16 1945 to January 26 1945
 that I last saw her alive on January 26 1945
 and that death occurred on the date and hour stated above.Immediate cause of death Brain tumor, left cerebellum
(Character undetermined) Duration 2 mo
 Due to malignantDue to _____
 Other conditions osteoporosis Many Years
 (Include pregnancy within 3 months of death)Major findings: None 545
 Of operations _____
 Of autopsy left cerebellar tumor 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? _____

23. Signature Frank Peaches (Specify type of place) _____
 (e) Means of injury _____
 Address 1630 Frank Blvd. Linn Co. Mo. Date signed _____

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..... *E. O. Toth*

Licensed Embalmer No. *1767*

P. O. Address *Kansas City*

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.