

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8432**
Registral's No. **1232**

FILED MAR 29 1945
Registration District No. **749**

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:
22 EAST-56TH STREET 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) **45 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**

(c) City or town **KANSAS CITY** **42**
(If outside city or town limits, write "RURAL") **2**

(d) Street No. **22 EAST-56TH STREET**
(If rural, give location) **8**

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MRS. DAISY FLORENCE ANDERSON**

(b) If veteran, name war **NO**

(c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **15TH**
year **1945** hour **7** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **January 17**, 19**45**, to **March 15**, 19**45**;
that I last saw her alive on **March 15**, 19**45**;
and that death occurred on the date and hour stated above.

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **MR WILLIAM F ANDERSON**

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

7. Birth date of deceased **AUGUST-8-1866**
(Month) (Day) (Year)

Immediate cause of death **Cerebral hemorrhage** Duration **2 weeks**

Due to **Cerebral arterio sclerosis and Essential hypertension** Several years

Due to _____

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

78 7 7 hr. min.

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

Major findings: _____

Of operations _____

Of autopsy _____

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

10. Usual occupation **AT HOME**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **MURRAY Mc DONALD**

13. Birthplace **WARRENTON VIRGINIA**
(City, town, or county) (State or foreign country)

14. Maiden name **MARGARET DAVIS**

15. Birthplace **RICHMOND MISSOURI**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **MRS. NELL PHILLIPS**

(b) Address **22 EAST-56TH STREET**

17. (a) **BURIAL** (b) Date thereof **MAR 17 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT WASHINGTON CEM.**

23. Signature **J. H. [Signature]** (M. D. or other) **MD**
Address **1836 Prof Bldg** Date signed **3/15/45**

18. (a) Signature of funeral director **D. H. Newcomer**

(b) Address **1401 BRUSH CREEK BLYD.**

19. (a) **3-17-45** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

Professional Body

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. Oscar 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.