

V. S. No. 2
 00M-5-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24134

State File No. _____

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 168

48
 14
 4

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Independence
 (c) Name of hospital or institution: Independence Sanitarium
 (d) Length of stay: In hospital or institution newborn
 In this community _____
 (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State newborn County 48
 (c) City or town Blue Springs, Mo.
 (d) Street No. _____
 (e) Citizen of foreign country? _____
 If yes, name country _____

3. (a) PRINT FULL NAME Dee Anna Anderson
 (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex F Color or race white
 5. Color or race _____
 6. (a) Single, widowed, married, divorced _____
 (b) Name of husband or wife _____
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 8 1945
 (Month) (Day) (Year)

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

9. Birthplace Independence Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation newborn

11. Industry or business _____

12. Name Wilee Anderson

13. Birthplace Mount Ash Ky
 (City, town, or county) (State or foreign country)

14. Maiden name Haley Cox
 (City, town, or county) (State or foreign country)

15. Birthplace Wood Creek Ky
 (City, town, or county) (State or foreign country)

16. (a) Informant Wilee Anderson
 (b) Address Blue Springs Mo

17. (a) burial (b) Date thereof 6-10-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Mrs. J. B. Anderson
 (b) Address Blue Springs Mo

19. (a) 6-10-45 (b) James W. Ross
 (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month June day 9
 year 1945 hour 1:00 minute _____ P. M.
 21. I hereby certify that I attended the deceased from June 8 1945 to June 9 1945
 that I last saw her alive on June 9 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Due to midforceps application at delivery on account of dystocia with acute sacral angle
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: none dry 1600
 Of operations _____
 Of autopsy none done

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 James W. Ross (M. D. or other) no
 Address Independence Mo Date signed 6-9-45

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

1143

(Licensed Embalmer's Statement on Reverse Side)

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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..... *R B Webb*

Licensed Embalmer No. *2353*

P. O. Address *Blue Springs 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.