

FILED JUL 21 1945

Registration District No. 177

Primary Registration District No. 5569

Registrar's No. 199

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: 4101 RAYTOWN ROAD. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 42 YEARS (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4101 RAYTOWN ROAD. 0
(If rural, give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country SWEDEN

3. (a) PRINT FULL NAME ESTHER ELIZABETH ANDERSON

3. (b) If veteran, name war NO 3. (c) Social Security No. 19019E

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife GUS ANDERSON 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased FEB - 2 - 1885 (Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 14 If less than one day hr. min.

9. Birthplace SWEDEN 4 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name GUS ANDERSON

13. Birthplace SWEDEN 4 (City, town, or county) (State or foreign country)

14. Maiden name MARIE LARSON (City, town, or county) (State or foreign country)

15. Birthplace SWEDEN 4 (City, town, or county) (State or foreign country)

16. (a) Informant MR. GUS ANDERSON

(b) Address 4101 RAYTOWN ROAD

17. (a) BURIAL (b) Date thereof JUNE 20 1945 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director O. N. Newcomer, Sons

(b) Address 1401 BRUSH CREEK BLVD. KCMO

19. (a) 6-19-45 (b) Mylaron (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 16th year 1945 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from December 1943 to June 16 1945 that I last saw her alive on June 16 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 7 days

Due to Acute Hypertension 10 years

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. Carl T. Mavie (M. D. or other) DO

Address 6508 E. 27th K.C. 3 MO. Date signed 6-19-45

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

MOTHER FATHER

9-1
6355

RECEIVED

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 Hesthey

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!

Registration District No. 147

Primary Registration District No. 5569

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town RURAL (BROOKING)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Esther E. Anderson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced SM

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

7. Birth date of deceased Feb 2 1892
(Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Sweden (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____

and that I last saw him/her alive on _____, 19____

and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

24135