

No. 2  
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-17-39  
X38671

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
**FILED JAN 9 1946** STANDARD CERTIFICATE OF DEATH

39988

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5250

**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: General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether)

In this community 15 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. #1407 Harrison  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** John Anders

3. (b) If veteran, name war World # I

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leta Anders

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Sept 20th 1892  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 20  
year 1945 hour 11 minute 25 A. M.

21. I hereby certify that I attended the deceased from Dec. 17 1945 to Dec. 20 1945  
that I last saw him alive on Dec. 20 1945  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>53</u>	<u>3</u>	<u>0</u>	hr. _____ min. _____

Immediate cause of death Acute myocardial infarction

Due to Coronary arteriosclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 94 a

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

10. Usual occupation Jointor & Apt Manager

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Thomas Anders

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

14. Maiden name Anna Little

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy See above

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

16. (a) Informant Mrs Leta Anders

(b) Address 1407 Harrison

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-22-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Clinton Missouri

18. (a) Signature of funeral director Consalus & Peck

(b) Address Clinton Missouri

19. (a) 12-21-45 (Date received local registrar) (b) Seraldine Holmes (Registrar's signature)

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 \_\_\_\_\_

3. Signature Clark W Sedgwick (M. D. or other) 12-20-45  
Address Med. Gen'l Hosp. Date signed \_\_\_\_\_

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

Dr. Kurch

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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. 26

working under my personal supervision.

Signed

Chas C. Weir

Licensed Embalmer No.

2644

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.**