

S. No. 2  
M-5-43  
5-17-39  
I X36671

**FILED** JAN 21 1945

Registration District No. 149

Primary Registration District No. 1002

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 8 days  
In this community 5 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1017 Holmes  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anton Anderson

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>			hr. min.

9. Birthplace Norway 11  
(City, town, or county) (State or foreign country)

10. Usual occupation none

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

12. Name Andres Anderson

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

14. Maiden name Marie Carlson

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 1

17. (a) Burial (b) Date thereof 1-3-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beds

18. (a) Signature of funeral director Wm. A. [unclear]

(b) Address City

19. (a) 12-31-45 (b) Stearline Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4  
year 1945 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 26 19 45 to Dec. 4 19 45  
that I last saw him alive on Dec. 4 19 45  
and that death occurred on the date and hour stated above.

Immediate cause of death Cause undetermined  
Duration \_\_\_\_\_

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

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

Other conditions 2000  
(Include pregnancy within 3 months of death)

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

Of autopsy None

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? \_\_\_\_\_

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

23. Signature Clark W. Seely (Type or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 12-4-45

100218  
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER, FATHER

**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.....

*Not Embalmed*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Wm A. Thompson*

Licensed Embalmer No.....

*3089*

P. O. Address.....

*11 E 7th*

**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.**