

S. No. 2
M-5-43
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

1153
5446

State File No. _____
Registrar's No. _____

FILED JAN 21 1946
Registration District No. 149

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
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 weeks
In this community since 1903
(Specify whether 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. 805 Newton Avenue
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Lillian Anderson
3. (b) If veteran, name war no.
3. (c) Social Security No. no.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 29
year 1945 hour 8:30 minute P. M.
21. I hereby certify that I attended the deceased from
November 2 1945 to December 29 1945
that I last saw h. er alive on December 29, 1945;
and that death occurred on the date and hour stated above.
Immediate cause of death Carcinoma of Rectum Duration 18 mo?

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Dr. W. Connelly Anderson
6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased: September 9 1875
(Month) (Day) (Year)

Due to Reaction following intra-venous medication postoperatively
Due to _____
Other conditions (Include pregnancy within 3 months of death) filed
Major findings: Adenocarcinoma of the Rectum (ampullar)
Autopsy Not done
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day
70 3 20 hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation at home
11. Industry or business X
12. Name Modglin
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Shirk
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Dr. W. C. Anderson
(b) Address 805 Newton, Kansas City, Mo.
17. (a) burial (b) Date thereof 1-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery
18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 12-31-45 (b) St. Geraldine Holmes
(Date received local registrar) (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 _____
23. Signature Leo K. Kille (M. D. or other)
Address 1103 Grand Avenue Date signed 12-31-

W. B. Bledsoe
E. N. Ginsburg

W. G. Thiele
Dr. G. Thiele,

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

W. B. Bledsoe

Licensed Embalmer No. 1413

P. O. Address. H. C. 128

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.