

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED APR 10 1946

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 Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution APPX. 1 hour
6 mos. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. 4002 E-18
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MICHAEL ANDERSON

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1946 hour 6 minute 10 M.

4. Sex MO **5. Color or race** W

6. (a) Single, widowed, married, Divorced **6. (c) Age of husband or wife if** single
alive _____ years

7. Birth date of deceased June 21 1943
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-31-1946 to 3-31-1946
that I last saw him alive on 3-31-1946
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>2</u>	<u>9</u>	<u>10</u>	hr. min.

Immediate cause of death
Atelectasis rt. middle lobe
Bronchopneumonia rt. middle lobe

Due to _____

Due to _____

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

10. Usual occupation none

11. Industry or business _____

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

Major findings:
Of operations _____

Of autopsy As above

MOTHER { **12. Name** Joseph Anderson

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

14. Maiden name Martin

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Joseph Anderson

(b) Address 4002 E-18

17. (a) Removal _____ **(b) Date thereof** Apr 1-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe Mo

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? _____

18. (a) Signature of funeral director Wm C L Gontier

(b) Address 718 Broadway

19. (a) 4-1-46 **(b) Geraldine Holmes**
(Data received local registrar) (Registrar's signature)

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

23. Signature Wm W. Hart (M. D. or other) WMO

Address Gen. Hosp. #1 **Date signed** _____

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

8181

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..... *B H Wise*

Licensed Embalmer No. *2570*

P. O. Address..... *120 2nd*

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.