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20132

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
**FILED JUL 2 1946** STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2711

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:  
K.C. Osteopathic Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Hrs.  
5 Months (Specify whether  
In this community \_\_\_\_\_  
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. 1221 Admrial  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Michael Lee Anderson  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 18  
year 1946 hour 2:30 minute 0 M.  
21. I hereby certify that I attended the deceased from  
born, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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 Jan 15 1946  
(Month) (Day) (Year)

Immediate cause of death  
Pneumo. pneumonia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death)  
107

8. AGE: Years Months Days If less than one day  
0 5 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Kansas City Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Infant

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no  
Histology & Pathology  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name Marvin Anderson  
13. Birthplace Minn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Alice Mathews  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
16. (a) Informant Marvin Anderson  
(b) Address 1221 Admrial  
17. (a) Burial (b) Date thereof June 20 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn Cem.  
18. (a) Signature of funeral director Mrs. C.L. Forster  
(b) Address 918 Brooklyn  
19. (a) 6-19-46 (b) Stheraldine 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 James Walker (M. D. or other)  
Address 1424 2nd St Date signed 6-18-46

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
19005

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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.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**