

3. No. 2  
-12-45  
5-17-39  
X47070

FILED JAN 27 1947

State File No. \_\_\_\_\_  
Registrar's No. **151**

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:  
3035 Main Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX  
25 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME TOM ANDERSON

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 499-10-1621

4. Sex Ma 5. Color or race wh

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

6. (b) Name of husband or wife May Anderson

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

7. Birth date of deceased January 21 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52 11 20 hr. min.

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

10. Usual occupation Proprietor

11. Industry or business Anderson Cafe

MOTHER FATHER

12. Name Willis Anderson

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

14. Maiden name Kate May Dobson

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

16. (a) Informant Mrs. May Anderson

(b) Address 4342 Garfield

17. (a) Burial (b) Date thereof 1-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 1-13-47 (b) Steraldine Holmes  
(Date received local registrar) (Registrar's signature)

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. 4342 Garfield  
(If rural, give location)

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11th  
year 1946 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from June 1946 to Jan 11 1947  
that I last saw him alive on Jan 11 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Acute purulent pericarditis and hemorrhage from aorta  
Due to aorta (a.s.)  
Bronchopneumonia + Ephysema  
Due to \_\_\_\_\_

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

Major findings: 107  
Of operations \_\_\_\_\_

Of autopsy acute purulent pericarditis + hemorrhage from aorta  
bronchopneumonia + ephysema

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 2

23. Signature C. B. Pector (M. D. or other)  
Address 1204 Prospect Date signed 1-11-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

FEB 19 1942

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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 Cecil R. Matthes

Licensed Embalmer No. 3807

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.