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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8883

State File No. _____
Registrar's No. **1407**

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: **St. Joseph Hospital** **D**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 days** (Specify whether years, months or days)

In this community **as above**

3. (a) PRINT FULL NAME **Baby Anderson**

3. (b) If veteran, name war **no.**

3. (c) Social Security No. **no.**

4. Sex **male** 5. Color or race **white**

6. (a) Single widowed, married, divorced **infant**

6. (b) Name of husband or wife **X**

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

7. Birth date of deceased **March 19 1947**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
-	-	3	hr. min.

9. Birthplace **Missouri** **D**
(City, town, or county) (State or foreign country)

10. Usual occupation **infant**

11. Industry or business **X**

MOTHER FATHER { 12. Name **Kenneth Anderson**

13. Birthplace **unknown** **7**
(City, town, or county) (State or foreign country)

14. Maiden name **Lucille**

15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kenneth Anderson**

(b) Address **Plattsburg, Missouri**

17. (a) **removal** (b) Date thereof **3-25-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Plattsburg, Missouri**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **3-26-47** (b) **Sheldine Holme**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Platte** **83**

(c) City or town **Plattsburg,** **0**
(If outside city or town limits, write "RURAL")

(d) Street No. **X** **1**
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **22**
year **1947** hour **9:40** minute **A.** M.

21. I hereby certify that I attended the deceased from **Pathologist** to **19**
that I last saw h. alive on **19**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Embolism, Bilateral**

Due to **Cause undetermined**

Due to _____

Other conditions **161a**
(Include pregnancy within 3 months of death)

Major findings: **161a**

Of operations _____

Of autopsy **Abund**

Duration _____

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? **5**

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

23. Signature **Sheldine Holme** (M.D. or other) **25 Mar 47**

Address **St. Joseph Hospital** Date signed _____

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

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. 1415

P. O. Address 1900 W. 1st St.

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.