

FILED APR 8 1947
 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 **K.C. MO.**
 (c) Name of hospital or institution:
Admiral Blvd. & Cherry
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3** (Specify whether
 In this community **44 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **JACKSON 48**
 (c) City or town **KANSAS CITY, MO. 3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1523 WOODLAND 8**
 (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME **FRANK SANDERSON**
 3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **3** day **25**
 year **1947** hour **2** minute **10-P.** M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**
 6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **November 1875**
 (Month) (Day) (Year)

Immediate cause of death _____
Cardiac Failure
 Due to _____
Hypertensive Heart Disease (?)
 Other conditions _____
 (Include pregnancy within 3 months of death) **Senility**
 Major findings: _____
 Of operations _____
 Of autopsy **No - Permit**

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

8. AGE:	Years	Months	Days	If less than one day
	71 72	4		hr. min.

9. Birthplace **TENN 1** (City, town, or county) (State or foreign country)
 10. Usual occupation **CHAUFFEUR**
 11. Industry or business **MRS. FRANK C. NILES**
 12. Name **PETER J. SANDERSON**
 13. Birthplace **TENNA 1** (City, town, or county) (State or foreign country)
 14. Maiden name **LOU HOLMES**
 15. Birthplace **TENNY** (City, town, or county) (State or foreign country)

16. (a) Informant **Charles Sanderson (bro)**
 (b) Address **Barstow School (50+ Cherry)**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-29-47** (Month) (Day) (Year)
 (c) Place: burial or cremation **Highland**
 18. (a) Signature of funeral director **W. J. Greenstreet**
 (b) Address **1819 E. 15th K.C. MO.**
 19. (a) **3-28-47** (Date received local registrar) (b) **Heraldine Holmes** (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 **Deputy 3**
 23. Signature **H. Williams** (M. D. or other) **Deputy 3**
 Address **2634 Brooklyn** Date signed _____

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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..... *C. P. Davis*

Licensed Embalmer No. *4417*

P. O. Address *75 E. 9000*

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.