

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 HOSPITAL NO. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 DAYS**
(Specify whether
In this community **26 YRS.**
years, months or days)

3. (a) PRINT FULL NAME **ANNA CHANEY**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **JOHN CHANEY** 6. (c) Age of husband or wife if alive **unk.** years
7. Birth date of deceased **AUGUST 20, 1880**
(Month) (Day) (Year)

8. AGE: Years **66** Months **10** Days **22** If less than one day hr. min.

9. Birthplace **KNOXVILLE MISSISSIPPI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

MOTHER FATHER { 12. Name **HARRY COTTEN**
13. Birthplace **MISSISSIPPI**
(City, town, or county) (State or foreign country)
14. Maiden name **JENNIE**
15. Birthplace **MISSISSIPPI**
(City, town, or county) (State or foreign country)

16. (a) Informant **JOHN CHANEY (HUSBAND)**
(b) Address **1523 CHERRY**

17. (a) **Removal** (b) Date thereof **7-15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Westview Cemetery - C-1**

18. (a) Signature of funeral director **Walter W. Platter** (Specify type of place)

(b) Address **1520 1/2 5th St.**

19. (a) **7-15-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON** **48**
(c) City or town **KANSAS CITY** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **1523 CHERRY** **8**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No) **0**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **12**,
year **1947** hour **4:** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **JULY 8, 1947** to **JULY 12, 1947**
that I last saw her alive on **JULY 12, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL VASCULAR ACCIDENT** Duration

Due to **HYPERTENSIVE TYPE OF HEART DISEASE**

Due to **GENERALIZED ARTERIOSCLEROSIS**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **932**
Of operations
Of autopsy
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?

(Specify type of place) means of injury

23. Signature **Frank [Signature]** (M. D. or other) **M. D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **7/14/47**

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. 2788
P. O. Address T. E. K.

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.