

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26120**
Registrar's No. **3320**

Registration District No. **119**

Primary Registration District No. **1008**

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

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3
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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'S HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 DAY** (Specify whether
In this community **unknown** years, months or days)

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. **8019 FLORA AVENUE 8**
(If rural, give location)
(e) Citizen of foreign country? **YES 0** (Yes or No)
If yes, name country **SWEDEN**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **15-TH**
year **1948** hour **5** minute **46 A.M.**

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

Immediate cause of death **Acute and chronic Pulmonary edema with multiple pulmonary infarctions, myocardial failure** Duration
Hypertensive arteriosclerotic heart disease
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: **93 2** PHYSICIAN
Of operations _____
Of autopsy **As above**
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **MRS. AMANDA ANDERSON**

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

4. Sex **FEMALE** 5. Color of race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **MR. JOHN E. ANDERSON** 6. (c) Age of husband or wife if alive **unk.** years
7. Birth date of deceased **FEBRUARY 9 - 1873**
(Month) (Day) (Year)

8. AGE: Years **75** Months **6** Days **6** If less than one day hr. min.

9. Birthplace **SWEDEN 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

12. Name **UNKNOWN JOHNSON 4**

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

14. Maiden name **UNKNOWN 1**

15. Birthplace **SWEDEN 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. JOHN E. ANDERSON**

(b) Address **8019 FLORA AVENUE**

17. (a) **CREMATION** (b) Date thereof **AUGUST 16 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DW. NEWCOMER'S SONS**

18. (a) Signature of funeral director **DW. Newcomer's Sons**

(b) Address **1401 Birch Creek Blvd**

19. (a) **8-16-48** (b) **Seraldine 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 **Robert N. Heas** (M. D. or other) **MD 0**

Address **St. Joseph Hosp** Date signed **8-15-48**

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 Edward M. Storey
Licensed Embalmer No. 4452
P. O. Address K. C. 4 m

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.