FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 26 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26588

Primary Registration District No. 1002

Registrar's No. 2087

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

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: K.C.General Hospital No.1 (If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution: 18 days (Specify whether years, months or days)
In this community: 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City (If outside city or town limits, write "RURAL") 3
(d) Street No.: 4953 Bales (If rural, give location) 8
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country:

3. (a) PRINT FULL NAME: Anna Sawyer

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Fe

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Geo. W. Sawyer

6. (c) Age of husband or wife if alive or if deceased, years: deceased

7. Birth date of deceased: August (Month) 29 (Day) 1869 (Year)

8. AGE: Years 78 Months 11 Days 12 If less than one day: hr. min.

9. Birthplace: Salina (City, town, or county) Iowa (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: At home

MOTHER FATHER
12. Name: Germund Johnson
13. Birthplace: No Record (City, town, or county) Sweden (State or foreign country) 4
14. Maiden name: Charlotte Gustafson
15. Birthplace: No Record (City, town, or county) Sweden (State or foreign country) 4

16. (a) Informant: Mr. A.W. Sawyer
(b) Address: 4953 Bell, K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-13-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Moriah Cemetery

18. (a) Signature of funeral director: Gates Funeral Home
(b) Address: 1901 Olathe Blvd. K.C. K.

19. (a) 8-13-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 11th year: 1948 hour: 8 minute: 50 P.M.

21. I hereby certify that I attended the deceased from 7-20-48, 19__, to 8-11-48, 19__; that I last saw her alive on 8-11-48, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: multiple carcinomatosis Primary unknown — Duration

Due to:

Due to:

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

Major findings: Of operations:

Of autopsy: See above

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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: Wm. W. Hart (M. D. or other) Md
Address: Med.Dir.K.C.Gen.Hospital K.C.Mo. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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 Jimmy S. Huckabee

Licensed Embalmer No. 4092

P. O. Address Marion, Ala.

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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26588/48

Registration District No. 949 Primary Registration District No. 1002 Registrar's No. 3297

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: Gen. Hosp. #1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Anna Sawyer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 8-13-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug - day 11 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 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 Multiple carcinomatosis primary vulva

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 49 d

Major findings:
Of operations

Of autopsy see above

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

1948
S-26588