

FILED JAN 15 1949

Registration District No. 149

MISSOURI DIVISION OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. 40000

Registrar's No. 5348

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 KANSAS CITY  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: ST LUKES 0  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 30 DAYS  
(Specify whether years, months or days)  
 In this community 20 DAYS

3. (a) PRINT FULL NAME Burt Anderson

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married  
 divorced m  
 6. (b) Name of husband or wife CATHERINE B. 6. (c) Age of husband or wife if alive APP. 50 years  
 7. Birth date of deceased 7 2 1892  
(Month) (Day) (Year)

8. AGE: Years 56 Months 5 Days 28 If less than one day hr. min.

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

10. Usual occupation DAIRY MAN

11. Industry or business CREAMERY CO

12. Name B. E. Anderson

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

14. Maiden name Maie Purmess

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

16. (a) Informant MRS CATHERINE B. ANDERSON

(b) Address OTTAWA, KANS

17. (a) REMOVAL (b) Date thereof 12 30 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OTTAWA, KANS

18. (a) Signature of funeral director SPINA M C CLURE

(b) Address K. C. M.

19. (a) 12-31-48 (b) Heraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 999  
 (a) State Kansas (b) County 12  
 (c) City or town OTTAWA  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 933 So MAIN  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30  
 year 1948 hour 1 minute 00 P. M.

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

Immediate cause of death Hemorrhage into cyst of kidney, right  
 Due to Hypertension

Due to Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations same

Of autopsy same

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. Signatures E.C.H. Schmidt (M. D. or other) \_\_\_\_\_  
 Address St. Lukes Hospital Date signed 30 December 1948

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 21 1949

MAR 21 1949

---

---

**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..... Robert H. Reef .....

Licensed Embalmer No. 3745 .....

P. O. Address. B. C. Ma .....

**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.**