

FILED JUN 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19856

State File No.

2428

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).				
a. COUNTY Jackson		a. STATE Kansas		b. COUNTY Johnson				
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. LENGTH OF STAY (In this place) 3 WKS.		c. CITY (If outside corporate limits, write RURAL and give township) Rural - Mission		9 11		
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital				d. STREET ADDRESS (If rural, give location) 5931 - Outlook				
3. NAME OF DECEASED (Type or Print)		a. (First) ANNA		b. (Middle) JONES		c. (Last) VICKERS		
4. DATE OF DEATH		(Month) (Day) (Year)		6 - 2 - 49				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 9-18-1873		
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Andrew Jones			13b. MOTHER'S MAIDEN NAME Mary Dillion		14. NAME OF HUSBAND OR WIFE Frank Vickers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. B.W. Diggle - Alexandria, Mo.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH						
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause* (a) stating the underlying cause last.		DUE TO (b) <u>Chronic Pulmonary Emphysema 6/1/49</u>						
DUE TO (c) <u>Metastatic Carcinoma Unknown</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>pelvic - probably uterine</u>				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>175X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>5/12/49</u> , 19 <u>49</u> , to <u>6/2/49</u> , 19 <u>49</u> , that I last saw the deceased <u>alive on 6/2/49, 1949, and that death occurred at 4:45 p.m., from the causes and on the date stated above.</u>								
23a. SIGNATURE <u>L. R. Livingston</u> (Degree or title)				23b. ADDRESS <u>L. R. Livingston - see P.S. Cedar 108926 E 11th KC mo.</u>		23c. DATE SIGNED <u>6/3/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-4-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>6-3-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Han Shiffeth</u>		ADDRESS <u>Mission, Kansas</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

2206-22

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~~ _____

Student Embalmer No. _____

working under my personal supervision.

Signed Harold L. Eckert

Signed _____
Student Embalmer

Licensed Embalmer No. 3035

P. O. Address St. Catharines

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.