

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26423

State File No. \_\_\_\_\_

24  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>86</u>	
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Sedgwick</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>			c. LENGTH OF STAY (in this place) <u>1 year</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wichita</u>			d. STREET ADDRESS (If rural, give location) <u>214 N. Hillside</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>904 St. Louis Avenue</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 22, 1949</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bess</u>		b. (Middle) <u>A</u>		c. (Last) <u>Anderson</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Feb. 13, 1886</u>		9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Omaha, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Peter Petersen</u>			13b. MOTHER'S MAIDEN NAME <u>Viola Shoultz</u>		14. NAME OF HUSBAND OR WIFE <u>William Anderson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. J. P. Kinne, Ex. Springs, Mo.</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis, generalized</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of breast</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH  <u>7 yrs</u>  <u>170X</u>
19a. DATE OF OPERATION <u>1942</u>		19b. MAJOR FINDINGS OF OPERATION <u>Un Known</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>22 July, 1949</u> , to <u>22 July, 1949</u> , that I last saw the deceased alive on <u>22 July, 1949</u> , and that death occurred at <u>7:10 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>				23b. ADDRESS <u>Excelsior Springs Mo</u>		23c. DATE SIGNED <u>23 July 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 25, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>7/25/49</u>		REGISTRAR'S SIGNATURE <u>Barolene Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Claude Prichard</u>		ADDRESS <u>Ex Springs Mo.</u>	

RECEIVED AUG 9

District Health Officer No. 8,

District File Number.....

Date Filed 8-18-19 *2*

AUG 30 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.....

Student Embalmer No. ....

working under my personal supervision.

Signed Lindell K Jarman

Signed.....  
Student Embalmer

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs,

**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.