

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16629**
Registrar's No. **2186**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **2186**

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Johnson | |
| b. CITY (If outside corporate limits, write RURAL and give township) Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) Mission | |
| c. LENGTH OF STAY (in this place) 4 days | | d. STREET ADDRESS (If rural, give location) 6000 Howe Drive | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital | | | |

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|---|----------------------|---------------------------|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Lillie | b. (Middle) - | c. (Last) Anderson | 4. DATE OF DEATH (Month) (Day) (Year) May 13 1950 |
|---|----------------------|---------------------------|---|

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|----------------------|-------------------------------|---|---------------------------------------|---|--------------------------|---------------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2 | 8. DATE OF BIRTH Apr. 22, 1882 | 9. AGE (In years last birthday) (Months) (Days) 68 | IF UNDER 1 YEAR 0 | IF UNDER 24 HRS. 0 |
|----------------------|-------------------------------|---|---------------------------------------|---|--------------------------|---------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | 10b. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (State or foreign country) Nebraska | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME James C. Smith | 13b. MOTHER'S MAIDEN NAME Mary Nolan | 14. NAME OF HUSBAND OR WIFE Henry J. Anderson, deceased |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Gretchen Miles ADDRESS 6000 Howe Drive, Mission, Mo. |
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| 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis | | 4 days. |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis | | 10 years. |
| DUE TO (c) _____ | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. L. Hemiplegia. | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |

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| 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) _____ |
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| | | |
|---|--|---------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 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 **5-4 1950**, to **5-13 1950**, that I last saw the deceased alive on **5-13 1950**, and that death occurred at **9:30 A. m.**, from the causes and on the date stated above.

| | | |
|---|---|---------------------------------|
| 23a. SIGNATURE F. R. Byers (Degree or title) M.D. | 23b. ADDRESS 315 Alameda Rd., K.C. Mo. | 23c. DATE SIGNED 5-13-50 |
|---|---|---------------------------------|

| | | | |
|--|--------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | 24b. DATE 5/14/50 | 24c. NAME OF CEMETERY OR CREMATORY _____ | 24d. LOCATION (City, town, or county) (State) Fremont, Nebraska |
|--|--------------------------|--|--|

| | | |
|---|---|---|
| DATE REC'D BY LOCAL REG. 5-13-50 | REGISTRAR'S SIGNATURE Seraldine Holmes | 25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE ADDRESS Kansas City, Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Restored 2:00

Kure

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

J. J. Allen

Signed
Student Embalmer

Licensed Embalmer No. *1415*

P. O. Address *H. E. W.*

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.