

FILED APR 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11935**
Registrar's No. **1397**

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| BIRTH NO. _____ | | REG. DIST. NO. 149 | | PRIMARY REG. DIST. NO. 1002 | | Registrar's No. 1397 | |
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. LENGTH OF STAY (In this place) 3 1/2 year | | c. CITY OR TOWN Kansas City | | d. Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hosp. | | | | e. STREET ADDRESS (If rural, give location) 5501 Charlotte 387 1/2 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Miss Anne | | b. (Middle) CATHERINE | | c. (Last) Griese | | 4. DATE OF DEATH (Month) (Day) (Year) March 28, 1955 | |
| 5. SEX F | | 6. COLOR OR RACE White | | 7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) NEVER MARRIED | | 8. DATE OF BIRTH- Feb. 14, 1879 1899 | |
| 9. AGE (In years) 56 If UNDER 1 YEAR Days 56 Months 0 Years 0 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY St. Mary's Hosp. | | 11. BIRTHPLACE (City and State or Foreign Country) Walker, Kansas, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Joseph Griese | | 13b. MOTHER'S MAIDEN NAME Mary Robben | | 14. NAME OF HUSBAND OR WIFE 1/2 | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clement Griese Hays, 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* Generalized Carcinoma - ANTECEDENT CAUSES Tumor DUE TO (b) Ca. of left breast DUE TO (c) Ca. of left ovary II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years 4 years 2 years 190X | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 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) | | 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 Jan 1953 , to March 28, 1955 , that I last saw the deceased alive on 3-27, 1955 , and that death occurred at 2:50 A.M. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Hubert M. Barker (Degree or title) MD | | | | 23b. ADDRESS 520 Argyle, N.C. Mo | | 23c. DATE SIGNED 3-28-55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE March 29, 1955 | | 24c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery | | 24d. LOCATION (City, town, or county) (State) Russell, Mo. | |
| DATE REC'D BY LOCAL REG. 3-29-55 | | REGISTRAR'S SIGNATURE Neva Minshall | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thos. E. Quirk 4316 Roost Ave. | | | |

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

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..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**

will call