

FILED AUG 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26019**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 909							
1. PLACE OF DEATH a. COUNTY Buchanan.				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 town) St. Joseph.			c. LENGTH OF STAY (in this place) 1 Mo. 19 days	c. CITY OR TOWN Kansas City.		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No. 2.				e. STREET ADDRESS (If rural, give location) 3321 Harrison.				34					
3. NAME OF DECEASED (Type or Print)		a. (First) LETA.		b. (Middle) MAE		c. (Last) ANNO.		4. DATE OF DEATH (Month) (Day) (Year) 8-20-1956.					
5. SEX Female.	6. COLOR OR RACE white.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married.		8. DATE OF BIRTH 8-31-1884.		9. AGE (in years last birthday) 71.	IF UNDER 1 YEAR Month's 11	IF UNDER 24 HRS. Days 19	Hours 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife.			10b. KIND OF BUSINESS OR INDUSTRY domesticatory.		11. BIRTHPLACE (City and State or Foreign Country) Milled, Kansas.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13a. FATHER'S NAME Aaron Dell.			13b. MOTHER'S MAIDEN NAME unknown.			14. NAME OF HUSBAND OR WIFE Trevor Anno.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no.		17. INFORMANT'S SIGNATURE OR NAME Trevor G. Anno, 3321 Harrison - K. C. Mo.					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH on admission					
<p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis.</p> <p>ANTECEDENT CAUSES</p> <p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) Asterio sclerosis.</p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>													
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)		4221							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 6-27-1956 , to 8-20-1956 , that I last saw the deceased alive on 8-20-1956 , and that death occurred at 5:20 P. m. , from the causes and on the date stated above.													
23a. SIGNATURE G.S. Waraich, M.D. (Degree or title) Doster Waraich, M.D.				23b. ADDRESS State Hospital No 2, St. Joseph, Mo.				23c. DATE SIGNED 8-20-1956.					
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 8/21/1956		24c. NAME OF CEMETERY OR CREMATORY Blue Mound Kansas		24d. LOCATION (City, town, or county) (State)							
DATE REC'D BY LOCAL REG Aug 22, 1956		REGISTRAR'S SIGNATURE Kathleen M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE Heaton - Bowman Funeral Home									

(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300
v. 10.48

J.M. HARRISON M.D., D.

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AUG 29 1956

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 *William Spelling*.....

Licensed Embalmer No. *4535*.....

P. O. Address *319 S. 11th St*.....

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.