Health, & Welfare Public Service

. 300
1-57

FILED MAY 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13553
STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5372 Registrar's No. 73

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Greenwood — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City — Length of stay in 1b 2 Yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Greenwood 1600 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS City (If outside, give location) — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First Middle Last: Thena Catherine Anderson

4. DATE OF DEATH Month April Day 16 Year 1957

5. SEX Female 6. COLOR OR RACE White 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH Mar. 1o 1880

9. AGE (In years last birthday) 77 — 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 -*****

11. BIRTHPLACE (City and state or country) Tenn.

12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME John Martin

13b. MOTHER'S MAIDEN NAME Annie Dunham

14. NAME OF HUSBAND OR WIFE Bert Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ** (If yes, give war or dates of service) **

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Ruth Bevalo Address New Orleans La.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 4 1957 to april 16, 1957 and last saw her/him alive on april 16, 1957
Death occurred at 12 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William F. Hall (Degree or title) MD.

22b. ADDRESS Lee's Summit Mo

22c. DATE SIGNED 4-17-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Apr. 19 1957

23c. NAME OF CEMETERY OR CREMATORY Floral Hills

23d. LOCATION (City, town, or county) (State) Kansas City Jackson Mo.

24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapel K.C. Mo.

25. DATE RECD. BY LOCAL REG. 4-17-1957

26. REGISTRAR'S SIGNATURE N. B. Longford

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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Dr Bell

APR 30 1957

MAY 2 1957

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 Everett L. Bell

Licensed Embalmer No. 4864

P. O. Address Kansas City

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.