

Health, Welfare, Public Service

FILED SEP 19 1957

STANDARD CERTIFICATE OF DEATH

31667

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1005 Registrar's No. 4036

000 1 -57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2119 E. 70th Street</u>		STREET ADDRESS (If outside, give location) <u>2119 E. 70th Street</u>	
Length of stay in lb <u>27 years</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>LENORA</u> Last <u>ANDERSON</u>			4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1895</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Trinceton, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					

13a. FATHER'S NAME <u>Edward J. Judson</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Moss</u>		14. NAME OF HUSBAND OR WIFE <u>William A. Anderson Sr.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-22-617</u>		17. INFORMANT <u>William A. Anderson Sr.</u> Address <u>2119 E. 70th St. K.C. Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>11/20</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial sclerotic ht disease</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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. _____					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Jan 1955</u> to <u>Aug 1957</u> and last saw her alive on <u>23 Aug 57</u>		Death occurred at <u>6:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William C. Van Buskirk MD.</u> (Degree or title)		22b. ADDRESS <u>1418 Professional Bldg. KCMo</u>		22c. DATE SIGNED <u>27 Aug 57</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>AUG-29-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>1931-13th Street KANSAS CITY, MISSOURI</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-57</u>		26. REGISTRAR'S SIGNATURE <u>Wesley Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

William C. Van Buskirk MD. Only black ink or ribbon typewrite if possible. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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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 *Chester K. Brown*

Licensed Embalmer No. *4931*
P. O. Address *KE Mo*

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.