

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31668

STATE FILE NUMBER

3832

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

|  |  |   |   |   |   |  |   |  |
|--|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>                  |   |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Kansas City</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      | c. CITY<br>OR<br>TOWN <b>Kansas City</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Trinity Luth. Hosp. 3 wks.</b>  |  |   |   | Length of stay in lb  |   | d. STREET<br>ADDRESS <b>3748 Springfield</b>   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First <b>KENNETH</b>  |   | Middle <b>YORK</b>  |   | Last <b>ANDERSON</b>   |   |  |
| 4. DATE OF DEATH<br><b>Aug. 15, 1957</b>   |  | Month <b>Aug.</b>   |   | Day <b>15</b>   |   | Year <b>1957</b>   |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>July 10, 1904</b>   |   |  |
| 9. AGE (In years last birthday) <b>53 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |   | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>bill clerk</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>K.C. Southern R.R.</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Olathe, Kansas</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Thomas H. Anderson</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Jane Frain</b>  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT<br>Address<br><b>Mrs. Kenneth Anderson K.C.Ks.</b>    |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MONOCYTIC LEUKEMIA</b>   |  |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>April 1957</b>   |  |
| 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 (n)  |  |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>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.)<br><b>—</b>  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour _____<br>a. m. _____<br>p. m. _____  |  |   | 20d. INJURY OCCURRED<br>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.)<br><b>—</b>  |  |   | 20f. CITY, TOWN, OR LOCATION<br><b>KANSAS CITY</b>  |   | COUNTY<br><b>MO.</b>  |  | STATE<br><b>MO.</b>   |  |
| 21. I attended the deceased from <b>July 1957</b> to <b>Aug 15, 1957</b> and last saw her <b>8-15-57</b><br>Death occurred at <b>7:10</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |   |   |  |   |  |
| 22a. SIGNATURE<br>(Degree or title)<br><b>Carl D. Emira M.D.</b>   |  |   |   | 22b. ADDRESS<br><b>Cargyle Bldg., K.C., MO.</b>   |   | 22c. DATE SIGNED<br><b>8-16-57</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>8/17/57</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chapel Hill Cem.</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>Wyandotte Co. Kansas</b>         |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Geo. F. Porter &amp; Sons K.C.Ks.</b>  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>8-16-57</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Neva Minshall</b>                                    |   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Carl D. Emira

health, Welfare Public Service  
0  
1-56  
0  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.



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 *Chas. H. Rider*

Licensed Embalmer No. 340

P. O. Address 19th & Main  
Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.