t. Health,
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

44221
STATE FILE NUMBER 5643

FILED DEC 18 1957

Registration District No. 149 Primary Registration District No. 100X Registrar's No. 5643

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Gen'l Hosp. #1 — Length of stay in 1b 37 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 6405 E. 37 St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First James — Middle W. — Last Anderson

4. DATE OF DEATH: Month 11 — Day 26 — Year 1957

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-9-1884
9. AGE (In years last birthday): 73 — 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): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: Street Dept. City
11. BIRTHPLACE (City and state or country): Cooper Co. Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: JAMES H. ANDERSON
13b. MOTHER'S MAIDEN NAME: No RECORD
14. NAME OF HUSBAND OR WIFE: Mattie Johnson Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 496-09-4396
17. INFORMANT: William A. Anderson — Address: 3226 Smart

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) Carcinoma of sigmoid colon
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)

INTERVAL BETWEEN ONSET AND DEATH: 153+

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

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 Nov. 25, 1957, to Nov. 26, 1957 and last saw him alive on Nov. 26, 1957
Death occurred at 5:30 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: B. I. Burns M.D. (Degree or title)
22b. ADDRESS: 24th & Cherry
22c. DATE SIGNED: 11-27-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-30-57
23c. NAME OF CEMETERY OR CREMATORY: Mt. Washington
23d. LOCATION (City, town, or county): Kansas City (State): Mo

24. FUNERAL DIRECTOR: Sheil Funeral Home — ADDRESS: K.C. Mo.
25. DATE RECD. BY LOCAL REG.: 11-29-57
26. REGISTRAR'S SIGNATURE: Neva Mendahall

(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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

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 Harold P. Reich

Licensed Embalmer No. 4998

P. O. Address Kansas City, M

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.