

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021745

STATE FILE NUMBER

FILED JUL 8 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2976

300
-57 4

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY WYANDOTTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) Home RIVERVIEW NURSING		d. STREET ADDRESS 4529 FRANCIS	
3. NAME OF DECEASED First Middle Last ANNA Alice VANHAAFTEN		4. DATE OF DEATH Month Day Year JUNE 16 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-1972
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Noxville - Iowa
10c. CITIZEN OF WHAT COUNTRY? U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME W.I. Williamson		13b. MOTHER'S MAIDEN NAME MARY Virginia Mickey	
14. NAME OF HUSBAND OR WIFE William VANHAAFTEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Helen Terril	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X		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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT <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 April 21st 1959 to June 16, 1959 and last saw her alive on June 16, 1959 Death occurred at 7:25 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert F. Goodwin M.D.		22b. ADDRESS 5239 Catalina K.C.3, Kan	
22c. DATE SIGNED 6-18-59		23. NAME OF CEMETERY OR CREMATORY Floral Hill's Cem	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE 6-19-1959	
23c. LOCATION (City, town, or county) Kansas City		23d. STATE Missouri	
24. FUNERAL DIRECTOR Estes		25. DATE RECD. BY LOCAL REG. 6-18-59	
26. REGISTRAR'S SIGNATURE seva minshel			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.
Robert F. Goodwin

P. Williams

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 *Paul R. Williams*

Licensed Embalmer No. *5009*
P. O. Address. *Overland Park*

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.