

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024967

REGISTRATION DISTRICT NO. 49

PRIMARY REGISTRATION DISTRICT NO. 1002 REGISTRAR'S NO. 3520

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Jackson</i>						
b. CITY (If outside corporate limits give TOWNSHIP only) <i>Kansas City</i>		Length of stay in 1b <i>50 yrs.</i>		c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (IF NOT in hospital give location) <i>St. Joseph Hosp.</i>				d. STREET ADDRESS <i>612 West 32nd St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Dona</i> Middle <i>Josephine</i> Last <i>Anderson</i>				4. DATE OF DEATH Month <i>July</i> Day <i>19</i> Year <i>1959</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>9/18/1878</i>				
				9. AGE (last birthday) <i>83</i>		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>			
13a. FATHER'S NAME <i>Herman Stader</i>			13b. MOTHER'S MAIDEN NAME <i>Julia Lamay</i>			14. NAME OF HUSBAND OR WIFE <i>Oren U. Anderson</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Ruth Anderson</i> Address <i>Kansas City, Mo.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>one year</i>							INTERVAL BETWEEN ONSET AND DEATH <i>one year</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
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 <i>1958</i> to <i>7-19-1959</i> and last saw her <i>live</i> on <i>July 19, 1959</i> Death occurred <i>2:50</i> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>Geo. G. Stanley M.D.</i> (Deedee or title)				22b. ADDRESS <i>3105 Jefferson St.</i>				22c. DATE SIGNED <i>7/19/59</i> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 20, 1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Hope Cemetery</i>			23d. LOCATION (City, town, or county) <i>Kansas City, Kansas</i>			
24. FUNERAL DIRECTOR <i>Ralph Fulton</i> ADDRESS <i>1319 N 18 th st K.C.K.</i>			25. DATE RECD. BY LOCAL REG. <i>7-20-59</i>		26. REGISTRAR'S SIGNATURE <i>Reva Marshall</i>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

Geo. G. Stanley

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph F. [Signature]

Licensed Embalmer No. 303

P. O. Address K.C.K.

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