

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041355

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 4239 Registrar's No. 95

FILED DEC 12 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY **Jackson**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY **Jackson**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Lee's Summit** Length of stay in 1b **DOA**

c. CITY OR TOWN **Lee's Summit** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Lees Summit Clinic** Inside Limits Yes No

d. STREET ADDRESS **Route 1** (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED First **Robin** Middle **Kay** Last **Anders** 4. DATE OF DEATH Month **12** Day **2** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **9-24-61** 9. AGE (last birthday) **0**

IF UNDER 1 YEAR IF UNDER 24 HR
Months **2** Days **8** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Infant** 10b. KIND OF BUSINESS OR INDUSTRY **- - -** 11. BIRTHPLACE (City and state or country) **Kansas City, Mo.** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Charles Anders** 13b. MOTHER'S MAIDEN NAME **Phyllis Hollingsworth** 14. NAME OF HUSBAND OR WIFE **- - -**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Charles Anders, Rt. 1, Lees Summit, Mo.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Strangulation -**
DUE TO (b) **aspiration of milk**
DUE TO (c)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

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.) **aspirated milk**

20c. TIME OF INJURY Hour a.m. p.m. **12-2-61**

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.) **Home** 20f. CITY, TOWN, OR LOCATION **Lees Summit Jackson Mo** COUNTY **Jackson** STATE **Mo**

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **E. K. George** 22b. ADDRESS **2067 Palestine Ave** 22c. DATE SIGNED **12-5-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **12-4-1961** 23c. NAME OF CEMETERY OR CREMATORY **Palestine Cemetery** 23d. LOCATION (City, town, or county) (State) **Kansas City, Missouri**

24. FUNERAL DIRECTOR **E. K. George & Sons, Inc., Grandview, Mo** ADDRESS 25. DATE RECD. BY LOCAL REG. **12-5-1961** 26. REGISTRAR'S SIGNATURE **W. B. Longford**

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 *Stirling E. Bossard*
Licensed Embalmer No. 4911

P. O. Address *Grandview*

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.