

FILED APR 12 1940
Registration District No. 399

State File No. _____

Primary Registration District No. 1002

Registrar's No. 1069

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3917 Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 65 years
years, months or days)

8. (a) PRINT FULL NAME Mrs. Fattie A. Anderson

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 22, 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Brooklyn, New York
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Thrower 4
13. Birthplace England
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant R. T. Anderson
(b) Address Phillipsburg Kans
17. (a) Burial (b) Date thereof March 9, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Freeman Mortuary
(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) Mch 8, 1940 M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2516 Montgall
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7,
year 1940 hour _____ minute _____

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Acute coronary occlusion
Due to _____

Due to _____ 94B

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature W. L. Brown (M. D. or other) _____
Address 11 E. Mo. Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.