

JUN 17 1940
Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-21-40-4-25-40
(Specify whether
In this community 30 years
years, months or days)

3. (a) PRINT FULL NAME Anna Rife 160

3. (b) If veteran, name war no 3. (c) Social Security No. no

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

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 66 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation unemployed

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital #2

17. (a) _____ (b) Date thereof 5-9-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Wayle Pro

(b) Address 1728 Tracy

19. (a) May 8, 1940 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1529 Virginia
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 25
year 40 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from 4-21-, 1940, to 4-25-, 1940
that I last saw her alive on 4-25-, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Type of Heart Disease.

Due to _____
Due to _____

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 it occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. C. Church (M. D. or other)
Address Gen. Hosp. #2 Date signed 4-27-

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

A B Moore

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

A B Moore

Licensed Embalmer No. _____

25750

P. O. Address _____

1820 East 15th Ave

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.