

RECORDED MAR 14 1941

Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Mary's Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days
(Specify whether
 In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Clay **74**
 (c) City or town North Kansas City, Mo **0**
(If outside city or town limits, write "RURAL") **0**
 (d) Street No. Rt. #5
(If rural, give location) **1**
 (e) If foreign born, how long in U. S. A.? 53 years.

3. (a) PRINT FULL NAME ALFRED J. ANDERSON
 3. (b) If veteran, name war _____
 3. (c) Social Security No. 486-07-86

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Edna
 6. (c) Age of husband or wife if alive 47 years
 7. Birth date of deceased April 1887
(Month) (Day) (Year)

8. AGE: Years 53 Months 10 Days 18
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Supt. Presto-O-Lite Co.

11. Industry or business Presto-O-Lite Co.

MOTHER FATHER
 { **12. Name** Anton Anderson
 { **13. Birthplace** Sweden
(City, town, or county) (State or foreign country)
 { **14. Maiden name** Anne Arvidson
 { **15. Birthplace** Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edna R. Anderson
 (b) Address Rt. #5 No. Kansas City, Mo.
17. (a) Burial (b) Date thereof 2-22-1941
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Washington, K. C.

18. (a) Signature of funeral director Morton Fun. Home
 (b) Address 832 Armour Rd. No. K. C. Mo.
19. (a) 2/21/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. 19th day _____
 year 1941 hour 5:50 minute _____ A. M.
21. I hereby certify that I attended the deceased from Feb. 12, 1941
 19____, to Feb. 19, 19____
 that I last saw him alive on Feb. 19, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Thrombosis of coronary artery
 Due to acute ulcerative atherosclerosis of coronary artery.
 Due to _____
 Duration 7 days

Other conditions _____
(Include pregnancy within 3 months of death) 940

Major findings:
 Of operations _____
 Of autopsy Six
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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? **NO.**

While at work? _____ (Specify type of place)
 (e) Means of injury D
23. Signature Chas. Vincent M.D. (M. D. or other) **D**
 Address 800 Argyle Bldg Date signed 2/19/41

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 *Harold L. Johnson*

Licensed Embalmer No. *3605*

P. O. Address *North Hill*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5992
Registrar's No. 764

Registration District No. 399

Primary Registration District No. 1007

1. PLACE OF BIRTH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alfred J Anderson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Feb day 19
year 1941 hour _____ minute _____ M.

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ year _____
7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

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

8. AGE: Years 53 Months 10 Days 18 If less than one day _____ hr _____ min.

Due to _____
Due to _____

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

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

10. Usual occupation _____

Major findings:
Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/21/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature C. J. Vincent (M. D. or other)
Address 800 Argyle Bldg Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

S-5992