

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27302
Registrar's No. 2960

EP 12 1941
District No. 379

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(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 Jackson X 8
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 4324 Charlotte (If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th
year 1941 hour 2 minute 10 A.M. M.
21. I hereby certify that I attended the deceased from
7-28-41 19 to 8-4-41 19 ;
that I last saw her alive on 8-4-41 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis Duration _____

Due to Carcinoma of large intestine

Due to See above

Other conditions See above
(Include pregnancy within 3 months of death)

Major findings: See above
Of operations _____

Of autopsy See above

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? _____

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

23. Signature Dr. R. K. Thoma (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hosp. K.C. Mo. Date signed _____

3. (a) PRINT FULL NAME Anna Lee Updike

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

4. Sex F. 5. Color or race W. 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 Dec. 16th 1890
(Month) (Day) (Year)

8. AGE: Years 39 Months 7 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name William E. Updike

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

14. Maiden name Mary Waters

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

16. (a) Informant Record Clerk

(b) Address K.C. Gen. Hospital, K.C. Mo

17. (a) See above (b) Date thereof _____ (Month) (Day) (Year)
(Specify transmission, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director See above

(b) Address See above

19. (a) 9/4/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

[Handwritten Signature]

Licensed Embalmer No. 482

P. O. Address K. C. Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27302
Registrar's No. 2960

Registration District No. 399

Primary Registration District No. 1002

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:
(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)

3. (a) PRINT FULL NAME

Anna L. Updike

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race H

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8-4-41

(c) Place: burial or cremation

Higginsville, Mo

18. (a) Signature of funeral director

(b) Address

19. (a) 8-4-41

(Date received local registrar)

(b) M M Crowe

(Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19...; that I or saw him alive on... 19...; and that death occurred on the date and hour stated above. Immediate cause of death..... Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 21 1942

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Jackson
 (b) City or town Kansas, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of Hospital or institution:
General
 (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 20 yrs 43 24 charlat

3. (a) PRINT FULL NAME Anna Yu Updike

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

4. Sex F 5. Color or race W 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 Dec - 16 - 1890
 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 12. Name W. E. Updike
 { 13. Birthplace Pa. (City, town, or county) _____ (State or foreign country)
 { 14. Maiden name Mary Emily Waters
 { 15. Birthplace Mo. (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature J. Waters
 (b) Address _____

17. (a) Removal (b) Date thereof 8-4-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director W. E. Updike & Son
 (b) Address Higginsville Mo

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 4
 year 41 hour 12 minute 10 P. M.

21. I hereby certify that I attended the deceased from 8-4-41 to 8-4-41, 19____, and that death occurred on the date and hour stated above.

I last saw him alive on _____, 19____.

Immediate cause of death _____

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 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 W. E. Updike (M. D. or other) _____

Address _____ Date signed _____

Duration _____

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

REV. 8-1-39 I 10951

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.

(S2)- 27 '38 2

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.....

Arthur H. Hagen

Licensed Embalmer No. *539*

P. O. Address, *Hopkinton, Mo*

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.