

FILED OCT 13 1941

Registration District No. **399**Primary Registration District No. **1002**Registrar's No. **3413**

## 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:  
**5331 Highland**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **4 months 10 days**  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME **Maria M. Sanders**3. (b) If veteran, name war **---** 3. (c) Social Security No. **none**4. Sex **Female** 5. Color of race **White** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **July 14, 1858**  
(Month) (Day) (Year)8. AGE: Years **83** Months **1** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace **Illinois**  
(City, town, or county) (State or foreign country)10. Usual occupation **none**

11. Industry or business \_\_\_\_\_

12. Name **Michael Haire**13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)14. Maiden name **Maria O'Connor**15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)16. (a) Informant **Sister Camille**(b) Address **5331 Highland**17. (a) **Burial** (b) Date thereof **9/13/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **General Kansas**18. (a) Signature of funeral director **Frank & Robin Co.**(b) Address **Kansas City Mo.**19. (a) **9/12/41** (b) **M. M. Crow**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **49**  
 (c) City or town **Kansas City** **3**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **5331 Highland** **8**  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **Sept**  
year **1941** hour **2 45** minute **0** M.21. I hereby certify that I attended the deceased from **Sept 7** to **Sept 11**, 19**41**  
that I last saw her alive on **Sept 11**, 19**41**;  
and that death occurred on the date and hour stated above.Immediate cause of death **Broncho Pneumonia** Duration **3 Days**Due to **Generalized Arteriosclerosis**  
Due to **Cardiac Decompensation** **2 weeks**Other conditions **Broken Left Hip**  
(Include pregnancy within 3 months of death)Major findings:  
Of operations **None**Of autopsy **None**

## 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) **Acc**  
 (b) Date of occurrence **Sept 8, 1941**  
 (c) Where did injury occur? **Home** (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 **fall**

23. Signature **John T. Shennar** (M. D. or other) **CMO**  
Address **21402 Bryant Bldg** Date signed **9/12/41**

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**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 the above constitutes grounds for revocation of license.)**

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