

No. 2
4-13-40
7-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41122

State File No. _____

Registrar's No. **4803**

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**

(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 **1 mo. & 4 days**
(Specify whether)

In this community **unknown**
years, months or days

3. (a) PRINT FULL NAME **ANNA GOW**

3. (b) If veteran, name war **WW**

3. (c) Social Security No. **None**

4. Sex **F** | 5. Color or race **W** | 6. (a) Single, widowed, married, divorced **W. D.**

6. (b) Name of husband or wife **unknown** | 6. (c) Age of husband or wife if alive **12** years

7. Birth date of deceased **April 12 1893**
(Month) (Day) (Year)

8. AGE: Years **48** Months **8** Days **11** | If less than one day **hr. min.**

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

10. Usual occupation **Cook**

11. Industry or business _____

12. Name **Theresa Eton**

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

14. Maiden name **Stark**

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

16. (a) Informant **Record Clerk**

(b) Address **K.C. Gen Hospital**

17. (a) **Burial** (Burial, cremation, or removal) | (b) Date thereof **12-24-41**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mearney**

18. (a) Signature of funeral director **[Signature]**

(b) Address **12/23/41**

19. (a) **12/23/41** (Date received local registrar) | (b) **[Signature]** (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. **1720 Indiana**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23rd** year **1941** hour **12** minute **15** A.M. M.

21. I hereby certify that I attended the deceased from **11-19-41** to **12-23-41**, 19...; that I last saw her alive on **12-23-41**, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast with extensive metastases**

Due to **50**

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

Major findings: Of operations _____

Of autopsy **See above**

Duration _____

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) (c) Means of injury.

23. Signature **Wm R. Thon** (M. D. or other)

Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

FEB 10 1942

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, fact, should be so stated above.