

FILED APR 1 1942
Registration District No. **279**

Primary Registration District No. **1002**

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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:
435 West 57th Terrace,
(d) Length of stay: In hospital or institution X
In this community 36 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson,
(c) City or town Kansas City,
(d) Street No. 435 West 57th Terrace,
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mrs. Anna May Daniels,
(b) If veteran, name war X
(c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 15th
year 1942 hour 10:00 minute P. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife John Newton Daniels,
(c) Age of husband or wife if alive 64 years
7. Birth date of deceased April 30 1880

21. I hereby certify that I attended the deceased from April 25
1941, to March 15, 1942;
that I last saw her alive on March 15, 1941;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hypertension
Wekmanhage

8. AGE: Years 61 Months 10 Days 15
If less than one day hr. min.

Duration Sudden
Due to Hypertension 83rd yrs.

9. Birthplace Unknown
10. Usual occupation at home,

Other conditions Paralysis agitans yrs.
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER { 11. Industry or business X
12. Name W. I. Bell
13. Birthplace Unknown
14. Maiden name Eliza Masley
15. Birthplace Unknown

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

16. (a) Informant John Newton Daniels,
(b) Address 435 West 57th Ter., K.C., Mo.
17. (a) Burial (b) Date thereof 3-17-42
(c) Place: burial or cremation Mt. Washington Cem.
18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K.C., Mo.
19. (a) 3-17-42 (b) Dr. M. Crowe

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? _____
(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 Ernie W. Vetterlein (M. D. or other) 17
Address Plaza med Bldg Date signed 3-16-42

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*Please Med. Rec'd
J. P. M.*

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 _____

working under my personal supervision. _____
Registered Apprentice No. _____

Signed _____
[Handwritten Signature]

Licensed Embalmer No. 1415

P.O. Address _____
[Handwritten 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.