

S.No. 2
M-9-4-41
v. 5-17-39
X29484

16892

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 6 1942 99

Registration District No.

Primary Registration District No. 1002

Registrar's No. 2075

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: 2745 Olive Street
(d) Length of stay: In hospital or institution. 55 Years
In this community 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 2745 Olive Street
(e) Citizen of foreign country? No

3. (a) PRINTED FULL NAME Mrs. Anna Chambers
(b) If veteran, name war No
(c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mr. Millard F Chambers
6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased: September 2 1870
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 24
If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business ---

12. Name Benjamin Woulff
13. Birthplace Frankfort Germany
14. Maiden name Unknown
15. Birthplace England

16. (a) Informant M. F. Chambers
(b) Address 435 So. Wheeling

17. (a) Burial (b) Date thereof May 28, 1942
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director O. W. Newcomer
(b) Address 1401 Brush Creek Blvd.

19. (a) 5-28-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 26th
year 1942 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 1, 1942
19....., to May 26, 1942
that I last saw her alive on May 26, 1942
and that death occurred on the date and hour stated above

Immediate cause of death: Carcinoma of Colon
Duration 1 year

Due to: unknown

Due to: Metastasis to lung.
(Include pregnancy within 3 months of death)

Major findings: no
Of operations no
Of autopsy no

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. Signatures: M. F. Chambers (Informant)
M. M. Brown (Registrar)

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

361

715 Virginia Road
3:30 - 5:00 PM

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: *A. C. Newcomer Jr*
Licensed Embalmer No. *4043*
P. O. Address: *A. 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.