S. No. 2
I—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 5 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4973

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 968

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: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community 60 yrs. years, months or days)

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. Salem Home 3008 Baltimore
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

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3. (a) PRINT FULL NAME Ingred Anderson

3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Fe
5. Color or race Wh
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Olaf Anderson
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased May 10, 1862 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	9	14	hr. min.

9. Birthplace No Record (City, town, or county) Sweden 4 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business self

FATHER
12. Name Anders Hanson
13. Birthplace NorRecord (City, town, or county) Sweden 4 (State or foreign country)

MOTHER
14. Maiden name Kjerstina Munson
15. Birthplace No Record (City, town, or county) Sweden 4 (State or foreign country)

16. (a) Informant Mrs. Kjersti[illegible] Jackson
(b) Address 369 South Boeke K.C.Kans.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/43 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cemetery
18. (a) Signature of funeral director Gate Funeral Home
(b) Address 1901 Olathe Blvd. K.C.Kans.
19. (a) 2-25-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24th year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 9/25/ 1941, to Feb 24 1943; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial failure	6 days
Chr. myocarditis	2 yrs.
Due to	
93D	
Due to	
Other conditions Asthma (Cardiac) (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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature E C Cannon MD (M. D. or other)
Address 242 Plaza Med Bldg Date signed 2/24/43

(Licensed Embalmer's Statement on Reverse Side)

Dr. Cameron

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 Wm L Ward

Licensed Embalmer No. 3991

P. O. Address 309 E 67 St. Tpma

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.