

No. 2
5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5586

State File No.

FILED FEB 27 1943 149
Registration District No.

Primary Registration District No. 1002

Registrar's No. 715

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:
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 9 days
(Specify whether
In this community 14 years
years, months or days)

3. (a) PRINT FULL NAME Anna Westmoreland

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

4. Sex Female / 5. Color or race wh
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Jasper Franklin
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug 15 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 24
If less than one day hr. min.

9. Birthplace Jackson Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER {
12. Name Frederick S. Rice
13. Birthplace Michigan
(City, town, or county) (State or foreign country)
14. Maiden name Annie Eliza Hoover
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant William Westmoreland

(b) Address Independence mo. Rt # 2

17. (a) Burial (b) Date thereof Feb 11 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director W. F. Mitchell

(b) Address Independence mo

19. (a) 2-10-43 (b) M. M. Crowe
(Date received local Registrar) (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. 3009 Montgall
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9th
year 1943 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from 2-1-43 to 2-9-43, 19...
that I last saw her alive on 2-9-43, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic cardio renal vascular disease

Due to 1310

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy None

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) (e) Means of injury
23. Signature Drury R. Thone (M. D. or other)
Address Dir. K.C. Gen. Hospital signed

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

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

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed Henry J. Mitchell
Licensed Embalmer No. 3925
P. O. Address Endicott, Me.

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.