

FILED JUN 7 1943
Registration District No. **199**

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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days
(Specify whether years, months or days)

In this community 4 years

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. 3215 Campbell
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martha F. Anderson

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

4. Sex fe / 5. Color or race w 6. (a) Single, widowed, married. divorced widow

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

7. Birth date of deceased Aug 12 1856
(Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business same

12. Name August Lot

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

14. Maiden name Amendia Lot

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

16. (a) Informant Mrs Elva Davis

(b) Address 5408 Rockhill

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/43
(Month) (Day) (Year)

(c) Place: burial or cremation See Summit Mo

18. (a) Signature of funeral director Snow Mayberry

(b) Address Sen. Blue

19. (a) 5-20-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17 year 1943 hour 10 minute 25 P. M.

21. I hereby certify that I attended the deceased from April 28 1943 to May 17 1943 that I last saw her alive on May 17 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Acute circulatory failure etiology unknown

Due to Fracture right femur

Due to 1862

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Acc 123

(b) Date of occurrence Apr 25 1943

(c) Where did injury occur? apx K.C. Jack Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? Acc Fall
(Specify type of place) (Means of injury)

23. Signature Drury R. Thorne (M. D. or other)

Address _____ Date signed _____

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

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.....

Roy E. Snow

Licensed Embalmer No.....

2560

P. O. Address.....

Lin + Olive

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.