

FILED SEP 28 1943 9

Registration District No. 9

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
710 Wabash /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community 12 years _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson ?

(c) City or town Kansas City, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. 710 Wabash
(If rural, give location)

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

3. (a) PRINT FULL NAME Gunnard C. Anderson

3. (b) If veteran, name war _____ 3. (c) Social Security No. 122-07-6377

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Lavilla MoAvoy Anderson 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Feb. 5, 1908
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	35	7	8	hr. _____ min.

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

10. Usual occupation Bus Operator

11. Industry or business K.C. Public Service Co.

MOTHER FATHER

12. Name Frank Anderson

13. Birthplace Sweden 4
(City, town, or county) (State or foreign country)

14. Maiden name Marie Anderson

15. Birthplace Sweden 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lavilla Anderson

(b) Address 710 Wabash, K.C. Mo.

17. (a) Burial (b) Date thereof Sept. 17 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt St Marys Cemetery

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indep. Ave. K.C. Mo.

19. (a) 9-16-43 (b) J.E. Brown, Dep.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13
year 43 hour 4:15 minute P M.

21. I hereby certify that I attended the deceased from 9/13/43, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema & Angina

Due to Block discharge of left ventricle

Due to _____

Other conditions 179B
(Include pregnancy within 3 months of death)

Major findings of operations 13

Of autopsy See above

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

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

(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 [Signature] 3 9/13/43
Address _____ Date _____

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

Signed.....

Licensed Embalmer No.....

P. O. 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.