

FILED FEB 14 1944
Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH: JACKSON
 (a) County KANSAS CITY
 (b) City or town (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3312 TROOST AVE.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 15 years years, months or days)

3. (a) PRINT FULL NAME HEDGES, ANNA S.
 3. (b) If veteran, name war. NO 3. (c) Social Security No. NO

4. Sex Female 5. Color of race Wh 6. (a) Single, widowed, married, divorced DIVORCED
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: 67 Years Months Days If less than one day
 hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____
 12. Name Unknown
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs
 (b) Address _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-1944 (Month) (Day) (Year)
 (c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director SUODARTIT
 (b) Address 1224 E. Brown

19. (a) Jan 14, 1944 (Date received local registrar) (b) J. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County JACKSON
 (c) City or town KANSAS CITY (If outside city or town limits, write "RURAL")
 (d) Street No. 3312 TROOST AVE (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 11th
 year 1944 hour 9:35 minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____;
Deputy to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease Duration _____
 Due to _____
 Due to 43

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy Inspection & history

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
 23. Signature W. E. Walker (M. D. or other) M.D.
W. E. Walker Date signed 1/14/44

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.