

FILED APR 7 1944  
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:  
**5036 EUCLID AVENUE 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community **4 YEARS** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON** **48**

(c) City or town **KANSAS CITY** **8**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1500 WEST 37TH STREET**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **MRS ANNA L. MERZ**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **none**

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MR. JOHN H. MERZ** 6. (c) Age of husband or wife if alive **unk** years

7. Birth date of deceased **SEPTEMBER 21 1876**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **6** Days **3** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **KINMUNDY ILLINOIS**  
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business \_\_\_\_\_

12. Name **RESE EAGAN**

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

14. Maiden name **HARRIETT EAGAN**

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

16. (a) Informant **MR. JOHN H. MERZ**

(b) Address **1500 WEST 37TH STREET**

17. (a) **CREMATION** (b) Date thereof **MAR 27 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DW NEWCOMER'S SONS**

18. (a) Signature of funeral director **D.W. Newcomer's Sons**

(b) Address **1401 BRUSH GREEN BLVD**

19. (a) **3-27-44** (b) **D. E. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **24<sup>TH</sup>**  
year **1944** hour **3** minute **00 P.M.**

21. I hereby certify that I attended the deceased from **Jan 1944** to **March 24, 1944**  
that I last saw her alive on **Feb 28, 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer**

Due to **Metastasis (Apelony & Bone?)** **1+yr.**

Due to **Carcinoma of Breast** **2+yr.**

Other conditions (include pregnancy within 3 months of death) **50**

Major findings: Of operations **None reported. Ca**  
**Top Breast (Skirshole) 1942**

Of autopsy **None.**

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) **None**

(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]** (M. D. or other) \_\_\_\_\_  
Address **2413 Plaza New York** Date signed **3/25/44**

Plaza Medical Bldg

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC Mo.

**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.**