S. No. 2
M—8-43
5-17-39
1 X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13554

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1971

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: 2210 Bales 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 20 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 2210 Bales
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 3

If yes, name country

3. (a) PRINT FULL NAME Walter Anderson

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced 2 Widower

6. (b) Name of husband or wife Minnie Anderson

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased July (Month) 24 (Day) 1867 (Year)

8. AGE: Years 76 Months 9 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Walter Anderson
13. Birthplace No 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Ora S. Anderson
(b) Address 2210 Bales

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6. 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Wm C L Forster
(b) Address 918 Brooklyn

19. (a) 5-6-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1944 hour 3 minute P M.

21. I hereby certify that I attended the deceased from April 18, 1944, to May 2, 1944
that I last saw him alive on May 1, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acute cardiac failure	1/2 hour
Due to Chronic myocarditis	?
Due to Chronic nephritis	?
Other conditions — (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy ✓

31 b

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? ✓
(Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature H O Cone (M. D. or other) DO
Address 2722 Prospect Date signed 5/3/44

(Licensed Embalmer's Statement on Reverse Side)

2722 Prospect
10 Pm. Wed.

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 C. H. Wise

Licensed Embalmer No. 7570

P. O. Address K. C. 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.