

7. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
No. 1 X36671

FILED AUG 2 1944  
Registration District No. 149

Primary Registration District No. 1002

State File No. \_\_\_\_\_  
Registrar's No. 3025

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:  
3516 Summit Street,  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 or 4 months  
(Specify whether years, months or days)

In this community 60 years,

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Kansas City, 3  
(If outside city or town limits, write "RURAL") 2

(d) Street No. Lucerne Hotel,  
(If rural, give location)

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

If yes, name country X ?

3. (a) PRINT FULL NAME Mrs. Annie Laurie Lee

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female 5. Color or race White

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

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

7. Birth date of deceased June 11 1853  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

91 1 9 hr. min.

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

10. Usual occupation at home,

11. Industry or business X

12. Name unknown,

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

14. Maiden name unknown,

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

16. (a) Informant Mrs. Evison,

(b) Address Lucerne Hotel, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 7-22-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20th,  
year 1944 hour 10:20 minute P. M.

21. I hereby certify that I attended the deceased from July 1  
19 44 to July 20 19 44  
that I last saw h. alive on July 20 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis chronic Duration \_\_\_\_\_

Due to Arteriosclerosis

Due to \_\_\_\_\_

Other conditions 93 d.  
(Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy \_\_\_\_\_

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 H. P. Jones (M. D. or other) \_\_\_\_\_  
Address 309 E 10 St. 21 July 44  
date signed

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

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

MOTHER FATHER

Dr. K. P. Jones.

AUG 16 1944

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 E M. Plank  
Licensed Embalmer No. 1848  
P. O. Address N.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.