

FILED OCT 24 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3956

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: K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)  
 In this community about 4 years

3. (a) PRINT FULL NAME Anna Buckley  
 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 WIDOWED  
 6. (b) Name of husband or wife 6660--~~unk~~  
 6. (c) Age of husband or wife if alive ---- years  
 7. Birth date of deceased: FEBR. 25, 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>7</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation NONE

11. Industry or business NONE

MOTHER FATHER  
 12. Name NO RECORD  
 13. Birthplace NO RECORD  
(City, town, or county) (State or foreign country)  
 14. Maiden name NO RECORD  
 15. Birthplace NO RECORD  
(City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORDS GENL. HOSP. NO. 1  
 (b) Address KANSAS CITY, MO

17. (a) BURIAL (b) Date thereof OCT. 4, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director [Signature]  
 (b) Address 815 W. MAPLE AVE. INDEPENDENCE, MO.

19. (a) 10-3-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

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")  
 (d) Street No. 3929 Cypress 2  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2  
 year 1944 hour 12 minute 40 A. M.

21. I hereby certify that I attended the deceased from Sept. 30, 1944 to Oct. 2, 1944  
 that I last saw h. er alive on Oct. 2, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Encephalomalacia Duration \_\_\_\_\_

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

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

Other conditions 83 C  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy See above

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 A. E. Upsher (M. D. or other) MD  
 Address Med. Dir. Gen'l Hosp. Date signed 10-2-44

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

*Henry W. Stahl*

Licensed Embalmer No.

*3181*

P. O. Address

*Independence 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.**