

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36550

State File No. _____

FILED DEC 4 1944

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4576

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:
Gen. Hosp. #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-31-44-11-10-44
(Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 47
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2006 E. 19th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNA ADAIR
3. (b) If veteran, name war no 3. (c) Social Security No. 920

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John Adair 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased March 2 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 8 8 hr. min.

9. Birthplace Lincoln City | Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name Abe Roberson
13. Birthplace unk (City, town, or county) (State or foreign country)
14. Maiden name Catherine O'Neil
15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (c) Burial (d) Date thereof 11-15-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prison Okla

18. (a) Signature of funeral director N.B. Mason

(b) Address 1820 East 18th

19. (a) 11-14-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10
year 1944 hour 7:00 minute _____ P. M.
21. I hereby certify that I attended the deceased from Oct. 31
1944 to Nov. 10 1944;
that I last saw her alive on Nov. 10 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration _____

Due to Bronchiectasis

Due to _____

Other conditions: 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Same as 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 N. E. Brown (M. D. or other) _____

Address Gen. Hosp. #2 600 E. 22nd Date signed 11-14-44

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 me

A.B. Moore, Registered Apprentice No. _____
working under my personal supervision.

Signed

A.B. Moore

Licensed Embalmer No. 2410

P. O. Address

1820 E 18th St

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.