

FILED JAN 26 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 76

1. PLACE OF DEATH:

(a) County JACOBSON  
(b) City or town K.C. - no. 4450 WASH  
(c) Name of hospital or institution: 4450 Washington  
(d) Length of stay: In hospital or institution 1 month - 1  
In this community 1 month - 1

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BATES  
(c) City or town FOSTER  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? / (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LAURA R. ANDERSON

3. (b) If veteran, name war \* NO 3. (c) Social Security No. none

4. Sex F / 5. Color or race W / 6. (a) Single, widowed, married, divorced /  
6. (b) Name of husband or wife FRANK ANDERSON 6. (c) Age of husband or wife if alive 81 years  
7. Birth date of deceased FEB - 9 - 1862

8. AGE: Years 82-72-10 Months 29 Days 29 hr. min.

9. Birthplace MO - (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name SAMUEL BROWN  
13. Birthplace MO - (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 Doris Shelton (b) Address 4450 Wash - R.C. no.

17. (a) Burial (b) Date thereof Jan 10 - 1945 (c) Place: burial or cremation Foster Sw.

18. (a) Signature of funeral director J. E. Underwood (b) Address Butts no.

19. (a) 1-8-45 (b) J. E. Brown (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 8th year 1945 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from December 14, 1944 to January 8, 1945 that I last saw her alive on January 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Due to Coronary Sclerosis

Other conditions 940  
Major findings: Of operations  
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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature J. E. Underwood (M. D. or other) Address 1630 Prof Bldg. Date signed 1/18/45

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

copy of Prof. Body

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

*Dr. Spies, Head  
Prof. Messing -  
Assistant*

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**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 *John H. Underwood*  
Licensed Embalmer No. *3585*  
P. O. Address *Butte, 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.**