

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **2039**

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:
1025 Huntington Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no.**
In this community **4 months** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1025 Huntington Road**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Mrs. Emma J. Anderson**
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**
6. (b) Name of husband or wife **George Anderson**
6. (c) Age of husband or wife if alive **dec.** years
7. Birth date of deceased **January 23 1869**
(Month) (Day) (Year)

8. AGE: Years **76** Months **3** Days **18/16** If less than one day hr. min.

9. Birthplace **Iowa** (City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business **X**

MOTHER FATHER

12. Name **John**
13. Birthplace **Iowa** (City, town, or county) (State or foreign country)
14. Maiden name **Adams**
15. Birthplace **Iowa** (City, town, or county) (State or foreign country)

16. (a) Informant **Otto Wittmann**
(b) Address **1025 Huntington Road, K. C., Mo.**

17. (a) **removal** (Burial, cremation, or removal) (b) Date thereof **5-10-45** (Month) (Day) (Year)

(c) Place: burial or cremation **Iola, Kansas**

18. (a) Signature of funeral director **Stine & McClure**
(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **5-10-45** (Date received local registrar) (b) **Seraldine Holms** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **9** year **1945** hour **11:00** minute **A.** M.
21. I hereby certify that I attended the deceased from **May 8, 1945** to **May 8, 1945** that I last saw her alive on **May 8, 1945** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**
Due to **arteriosclerosis**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **94a**
Of autopsy **no**

Duration
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 **Jamie Walker** (M. D. or other) **Walker**
Address **1424 Poplar Rd** Date signed **5-8-45**

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

18
3
55

MAY 31 1945

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

Licensed Embalmer No. 1415

P. O. Address 17 C. M. 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.