V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

Registration District No. 799

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15829

Primary Registration District No. 1001

Registrar's No. 2299

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: (Home) 5103 E. 23rd. St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 39 years

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.: 5103 E. 23rd. St.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Anna Lou Darrah

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: Married

6. (b) Name of husband or wife: Charles Darrah

6. (c) Age of husband or wife if alive: 79 years

7. Birth date of deceased: June (Month) 25th. (Day) 1871 (Year)

8. AGE: Years 73 | Months 11 | Days 62 | If less than one day ____ hr. ____ min.

9. Birthplace: Carrollton (City, town, or county) Missouri (State or foreign country) U

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: John H. Caskey
13. Birthplace: (City, town, or county) Missouri (State or foreign country) U

MOTHER
14. Maiden name: Susan H. Buzzard
15. Birthplace: (City, town, or county) Va. (State or foreign country)

16. (a) Informant: Jim Caskey
(b) Address: 1835 Kensington Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/29/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Washington

18. (a) Signature of funeral director: Earp Funeral Home
(b) Address: 4139 East 15th. St.

19. (a) 5-29-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1945 hour 2 minute 20 P.M.

21. I hereby certify that I attended the deceased from May 25, 1945, to May 27, 1945, that I last saw him alive on May 27, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chr. Myocarditis with decompensation	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 93	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: C. M. Brunsell (M. D. or other) MD
Address: 708 W. 17th St. Date signed: 5/28/45

(Licensed Embalmer's Statement on Reverse Side)

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 B. Cooper

Licensed Embalmer No. 2955

P. O. Address N.C. MD

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.