. 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

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22790

FILED AUG 7 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3083

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Missouri (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7-17-45; 7-20-45 (Specify whether In this community 1 year years, months or days)

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. 1514 Harrison 8 (If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME WILL ANDERSON

3. (b) If veteran, name war no

3. (c) Social Security No. 438-14-0840

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced married /

6. (b) Name of husband or wife Josephine Anderson

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased 12 (Month) 23 (Day) 1902 (Year)

8. AGE: Years 42 Months 6 Days 27 If less than one day hr. min.

9. Birthplace Black Hawk (City, town, or county) Louisiana / (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Kansas City Terminal

FATHER
12. Name Jim Anderson
13. Birthplace (City, town, or county) Louisiana / (State or foreign country)

MOTHER
14. Maiden name Emma Minor
15. Birthplace (City, town, or county) Louisiana / (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 7/25/45 (Month) (Day) (Year)

(c) Place: burial or cremation Ferreday - La

18. (a) Signature of funeral director Watkins Bros

(b) Address 1729 Lydia

19. (a) 7-24-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1945 hour 12:45 minu p.m. M.

21. I hereby certify that I attended the deceased from 7-17-45, 19..., to 7-20-45, 19...; that I last saw him alive on 7-20-45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the Aesophagus

Due to Erosion into trachea

Due to Multiple Lung abcesses

Other conditions (Include pregnancy within 3 months of death) 1/6 a

Major findings: Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Gen. Hosp #2, 22nd Mtg Date signed 7-21-45

(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 Jerome Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highlan

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.