S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22877
Registrar's No. 29012

FILED JUL 23 1945

Registration District No. 1/2/9 Primary Registration District No. 1002

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: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 Day (Specify whether years, months or days)
In this community: 16 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 2
(If outside city or town limits, write "RURAL")
(d) Street No.: 2619 E. 27th 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Anna Almira Cox
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Female 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow 2
6. (b) Name of husband or wife: William Cox
6. (c) Age of husband or wife if alive: * years
7. Birth date of deceased: 3 (Month) 5 (Day) 1856 (Year)
8. AGE: Years 89 Months 4 Days 5 If less than one day: hr. min.
9. Birthplace: Illinois 1 (City, town, or county) (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
12. FATHER Name: Frederick Smith
13. FATHER Birthplace: Penn. 1 (City, town, or county) (State or foreign country)
14. MOTHER Maiden name: Rachael Wells
15. MOTHER Birthplace: Vermont 1 (City, town, or county) (State or foreign country)
16. (a) Informant: Mr. Cyrus Riley
(b) Address: 2619 East 27th. Street
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 7-10-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Moline, Illinois.
18. (a) Signature of funeral director: Mrs. C. L. Forster
(b) Address: Kansas City, Missouri
19. (a) 7-11-45 (Date received local registrar) (b) Geraldine Helmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year 1945 hour 1 minute 15 A.M.
21. I hereby certify that I attended the deceased from July 19, 1945, to July 10, 1945 that I last saw her alive on July 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Intertrochanteric fracture left hip
Due to: cardiac decompensation
Due to:
Other conditions (Include pregnancy within 3 months of death):
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): accident
(b) Date of occurrence: 7.9.45
(c) Where did injury occur? home K.C. Jackson Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? no (e) Means of injury: Fell
23. Signature: Clark A. Seely M.D. (M. D. or other)
Address: Med. Dir. K.C. General Hospital Date signed:

(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 Cortland S Minor

Licensed Embalmer No. 3414

P. O. Address 918 Brooklyn

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.