V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

FILED OCT 1 1945

State File No. 29634

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3887

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: Wheatley Provident Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 8 years
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. 2011 Montgall 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Anna Draffen

3. (b) If veteran, name war None

3. (c) Social Security No. 500-03-2871

4. Sex Fe 3

5. Color or race Col

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

6. (b) Name of husband or wife Willis Draffen

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

7. Birth date of deceased October (Month) 8 (Day) 1886 (Year)

8. AGE:

Years	Months	Days	If less than one day
58	11	9	hr. min.

9. Birthplace Bunceton (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Maid

11. Industry or business

FATHER
12. Name John Anderson
13. Birthplace (City, town, or county) Missouri (State or foreign country) 0

MOTHER
14. Maiden name Anna Clay
15. Birthplace (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Anna Belle Boyce
(b) Address 2023 Montgall

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 9/21/45 (Month) (Day) (Year)
(c) Place: burial or cremation Bunceton, Missouri

18. (a) Signature of funeral director Watkins Bros
(b) Address 1729 Lydia

19. (a) 9-20-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17
year 1945 hour 9:10 minute P. M.

21. I hereby certify that I attended the deceased from 9-15, 1945, to 9-17, 1945
that I last saw her alive on 9-17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Intestinal Obstruction

Due to (adhesions)

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations No 107

Of autopsy Yes

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 0

23. Signature J G Montgomery M D (M.D. or other)

Address B3r Prg. Bldg. Date signed 9-20-45

(Licensed Embalmer's Statement on Reverse Side)

Dr Montgomery

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 L. J. Marlowe

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.