

No. 2
-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5484**
Registrar's No. **622**

Registration District No. **149**

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: **St. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 weeks**
In this community **as above**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Kansas** (b) County **999**
(c) City or town **Manhattan**
(If outside city or town limits, write "RURAL")
(d) Street No. **606 Moro**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Miss Mary Jane Annan**
3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **February** day **6th**
year **1946** hour **2:30** minute **P.** M.
21. I hereby certify that I attended the deceased from **Jan 8, '46**
to **Feb 6, 1946**
that I last saw her alive on **Feb 6, 1946**
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive **X** years
7. Birth date of deceased: **Oct. 1**
(Month) (Day) (Year)

Status Asthmaticus 1 day
Due to **Bronchial Asthma 2 yrs**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
about 52 hr. min.

Major findings: **112**
Of operations _____
Of autopsy **Hypoplasia of lungs**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Kansas**
(City, town, or county) (State or foreign country)
10. Usual occupation **Alterations**
11. Industry or business **X**
12. Name **Robert L. Annan**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Winifred Edwards**
15. Birthplace **Wales**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bess Annan**
(b) Address **3930 Park, Kansas City, Mo.**
17. (a) **removal** (b) Date thereof **2-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Manhattan, Kansas,**

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)
Means of injury **O**

18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**
19. (a) **2-7-46** (b) **Seraldine Holman**
(Date received local registrar) (Registrar's signature)

23. Signature **M. J. Berry** (M. D. or other)
Address **Plaza Med. Bldg. K.C. Mo** Date signed **2-7-46**

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

18

4423

Mad. P. T. Bohan
Dr. P. T. Bohan

Dr. P. T. Bohan

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address. 14 C mo

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.