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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2509

**FILED JUN 20 1946**  
Registration District No. 177

Primary Registration District No. 1002

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

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: 5813 6/3 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 yrs years, months or days

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. 5813-E-13th  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillian Margaret Anderson

3. (b) If veteran, name war no (c) Social Security No. no

4. Sex Fe 1 | 5. Color of race wh | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John W Anderson | 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 22 1913 (Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City Mo (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Alex Erickson  
13. Birthplace Sveveden (City, town, or county) (State or foreign country)  
14. Maiden name Esther Martinson  
15. Birthplace Sveveden (City, town, or county) (State or foreign country)

16. (a) Informant Alex Erickson  
(b) Address 5813-E-13th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Green Haven

18. (a) Signature of funeral director Wm CR Forster  
(b) Address 918 Brooklyn St

19. (a) 6-7-46 (Date received local registrar) (b) Elizabeth Holman (Registrar's signature)

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month June day 6 year 1946 - hour 7 - minute 15 - A.M.

21. I hereby certify that I attended the deceased from May 15, 1946, to June 6, 1946 and that death occurred on the date and hour stated above.  
that I last saw her alive on June 6, 1946

Immediate cause of death Respiratory Failure  
Due to Pulmonary Tuberculosis 3 yrs -

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 13  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury 2

23. Signature Paul E. Forney (M. D. or other) Do  
Address 622 8 1/2 815th Date signed 6-6-46

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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..... *C. H. Wise* .....

Licensed Embalmer No. *2570* .....

P. O. Address..... *KC 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.**