

No. 2  
1-5-43  
5-17-39  
I X36871

Registration District No. 149 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:  
4324 Washington  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 WEEKS  
(Specify whether years, months or days) 3 years  
In this community 3 years  
(years, months or days)

3. (a) PRINT FULL NAME Anna Hall  
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Fe. 3. (c) Color or race Col.  
6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife Clarence Hall, Dec.  
6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased April 11 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 2 24 hr. min.  
28

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

10. Usual occupation Unemployed

11. Industry or business

MOTHER, FATHER { 12. Name Charlie Wolf  
13. Birthplace Lexington, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Cotes  
15. Birthplace Lexington, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Allegro Smith  
(b) Address 4324 Washington Street

17. (a) Burial (b) Date thereof 7-9-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Trinity Cemetery West, Appleton, Mo.

18. (a) Signature of funeral director W. E. Jones  
(b) Address 1905 Vine Street

19. (a) 7-9-47 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

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. 4324 Washington  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION  
20. DATE OF DEATH, Month July day 5  
year 1947 hour 10 minute 8 M.  
I hereby certify that I attended the deceased from 12-15-46 to 7-5-47  
that I last saw alive on 7-5-47  
and the death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure  
Due to Hypertensive Ht Disease  
Due to Chronic Parenchymatous Nephritis  
Other conditions (Include pregnancy within 3 months of death) no

Major findings: Of operations no Of autopsy no  
PHYSICIAN 1316  
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) no  
(b) Date of occurrence no  
(c) Where did injury occur? no (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no  
23. Signature J. J. [unclear] (M. D. or other) no  
Address W. E. Jones Date signed 7-8-47

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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. J. Huet*

Licensed Embalmer No. *2710*

P. O. Address *R. 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.