

No. 2  
-1/47  
5-17-39

FILED JUL 3 1948 49  
Registration District No.

Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 500 E 8th  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town K.C. (If outside city or town limits, write "RURAL")  
(d) Street No. 500 E 8th (If rural, give location)  
(e) Citizen of foreign country? unknown (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME JOHN A ANDERSON  
3. (b) If veteran, unknown name war  
3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 20  
year 48 hour 11 minute 9 M.  
21. I hereby certify that I attended the deceased from Coroner, 1948 to 1948, 1948 that I last saw h. alive on 1948 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced 9  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive

Immediate cause of death Coronary sclerosis  
Due to Smoked pipe auto valves  
Due to

8. AGE: Years Months Days If less than one day  
app 85 hr. min.

Other conditions (include pregnancy within 3 months of death) 93rd  
Major findings: Of operations  
Of autopsy: Coronary sclerosis  
History of angina

9. Birthplace (City, town or county) (State or foreign country)  
10. Usual occupation 9  
11. Industry or business 9  
12. Name 9  
13. Birthplace (City, town or county) (State or foreign country)  
14. Maiden name 9  
15. Birthplace (City, town or county) (State or foreign country)

22. If death is 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  
23. Signature John A. Anderson (M. D. or other) Coroner  
Address 1424 N 44 Date signed 6-22-48

16. (a) Informant Coroner's office  
(b) Address F.C. Mo  
17. (a) Removal Removal (b) Date thereof 6/23/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation K.C. College of Arts  
18. (a) Signature of funeral director Sebbeto's  
(b) Address 901 E. 5th  
19. (a) 6-13-48 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

PHYSICIAN  
Underline the cause of which death should be charged statistically.

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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

*Ray E Snow*

Licensed Embalmer No.

*2560*

P. O. Address

*756 W*

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.