

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30260**
3866

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) life		d. STREET ADDRESS (If rural, give location) 2701 Perry (PEERY)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital D			

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) A. c. (Last) FRICK	4. DATE OF DEATH (Month) (Day) (Year) Sept. 7, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 17, 1882	9. AGE (In Years last birthday) 67 yrs	IF UNDER 1 YEAR Months 67 Days 6 Hours 20 Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Jackson County, Missouri	
13a. FATHER'S NAME Patrick Noland			13b. MOTHER'S MAIDEN NAME Mary Kelley		14. NAME OF HUSBAND OR WIFE Henry C. Frick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Margaret Stoll 3025 Flora K.C. Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull (Base)		
	II. OTHER SIGNIFICANT CONDITIONS* auto + pedestrian		
*Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sub-dural Hemorrhage DUE TO (c) Comp. Fracture of Fibra			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION E 8:24 25	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident street	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jackson Co
21d. TIME OF INJURY 9-6:49 8:45 P	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Struck by auto

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. Owens (Degree or title)	23b. ADDRESS 1034 Prairie Blvd	23c. DATE SIGNED 9-7-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 9-10-49	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 9-8-49	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eyles Kansas City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 17 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.