

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43747
5469

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	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1201 Washington		d. STREET ADDRESS (If rural, give location) 1201 Washington	
3. NAME OF DECEASED a. (First) Nellie		b. (Middle) McAnany	
c. (Last) McAnany		4. DATE OF DEATH (Month) (Day) (Year) December 20, 1949	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Sept. 15, 1879
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (State or foreign country) 9
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Thomas	
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 Miss Mae McAnany		ADDRESS 1201 Washington	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral hemorrhage DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 10 yrs		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 1949, to Dec 20, 1949, that I last saw the deceased alive on Dec 20, 1949, and that death occurred at 8:15 P. m., from the causes and on the date stated above.			
23a. SIGNATURE Charles Glass (Degree or title) D.O. 2		23b. ADDRESS 808 West 17th	
23c. DATE SIGNED 12/23/49		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 12/23/49		24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		DATE REC'D BY LOCAL REG. 12-27-49	
REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 20 W. Linwood	

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

3008

Mr. Chas. Glaser
808 N. 17th

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

Forrest D. Coldman

Licensed Embalmer No. *4719*

P. O. Address *St. Louis 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.