

THE DIVISION OF HEALTH OF MISSOURI  
FILED MAY 6 1950 STANDARD CERTIFICATE OF DEATH

12817  
State File No. 1820

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Mo.</b> |  | b. COUNTY<br><b>Jackson</b>  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>Kansas City</b> |  | c. LENGTH OF STAY (in this place)<br><b>65 yrs</b>   |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>Kansas City</b> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2208 Lister</b>                              |  | d. STREET ADDRESS (If rural, give location)<br><b>2208 Lister</b>  |  |  |  |

|   |  |             |  |                              |  |  |  |
|---|--|-------------|--|------------------------------|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First)<br><b>MOLLIE</b> |  | b. (Middle) |  | c. (Last)<br><b>ANDERSON</b> |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>4/18/50</b> |  |
|---|--|-------------|--|------------------------------|--|--|--|

|                           |  |                               |  |   |  |                                     |  |  |  |                                |  |                               |  |
|---------------------------|--|-------------------------------|--|---|--|-------------------------------------|--|--|--|--------------------------------|--|-------------------------------|--|
| 5. SEX<br><b>Fem / Wh</b> |  | 6. COLOR OR RACE<br><b>Wh</b> |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Wid. 2</b> |  | 8. DATE OF BIRTH<br><b>9/8/1863</b> |  | 9. AGE (In years last birthday)<br><b>76 8/6</b> |  | IF UNDER 1 YEAR<br>Months Days |  | IF UNDER 4 HRS.<br>Hours Min. |  |
|---------------------------|--|-------------------------------|--|---|--|-------------------------------------|--|--|--|--------------------------------|--|-------------------------------|--|

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Missouri D</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |  |
|---|--|---|--|--|--|--|--|

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME<br><b>Frank Ford</b> |  | 13b. MOTHER'S MAIDEN NAME<br><b>Martha Baldwin</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Geo. E. Anderson, Dec.</b> |  |
|---|--|--|--|--|--|

|  |  |                                      |  |   |  |
|--|--|--------------------------------------|--|---|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |  | 16. SOCIAL SECURITY NO.<br><b>no</b> |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Step Son, Geo. E. Anderson, 2208 Lister</b> |  |
|--|--|--------------------------------------|--|---|--|

|   |  |   |  |  |  |                                  |  |
|---|--|---|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio Sclerotic Heart Disease</b>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____             |  |  |  |                                  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death<br><b>Infantile Paralysis 20 yrs H.A. 1930</b> |  |  |  |                                  |  |

|                        |  |                                  |  |  |  |   |  |
|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|--|---|--|

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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><b>Natural</b> |  | 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) (m.)       |  | 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 \_\_\_\_\_, 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<br><b>Hugh H. Owens</b> (Degree or title) |  | 23b. ADDRESS<br><b>1034 Rearto Bldg</b> |  | 23c. DATE SIGNED<br><b>4-19-50</b> |  |
|--|--|---|--|------------------------------------|--|

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24b. DATE<br><b>4/21/50</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>St. Marys Cemetery</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Mo.</b> |  |
|--|--|-----------------------------|--|---|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| DATE REC'D BY LOCAL REG.<br><b>4-19-50</b> |  | REGISTRAR'S SIGNATURE<br><b>J. H. Holmes</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>John P. Sheil, K. C. Mo.</b> |  |
|--|--|--|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

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

Rev. H. H. Linn  
Funeral Home

**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 \_\_\_\_\_

*Richard E. Carroll*

Student Embalmer No. *368*

working under my personal supervision.

Student *Richard E. Carroll*  
Student Embalmer

Signed *John P. Shick*

Licensed Embalmer No. *3625*

P. O. Address *K 6. 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.