

FILED APR 19 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13412

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Praire Rural</b> )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Independence</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jackson Co. Emergency Hosp</b>		d. STREET ADDRESS (If rural, give location) <b>301 W. College</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>MISS. ANNA</b>		c. (Last) <b>KREY</b>	
b. (Middle) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>March 30, 1950</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Aug. 7, 1870</b>
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Independence, Mo</b>
12. CITIZEN OF WHAT COUNTRY? <b>usa</b>		13a. FATHER'S NAME <b>Peter Krey</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Albright</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Howard Shepard</b>		ADDRESS <b>Indep. Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Carcinoma of ovary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION <b>28 Mar 49</b>	
19b. MAJOR FINDINGS OF OPERATION <b>Metastasis to broad lig. &amp; sigmoid</b>		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) (Min.)	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 <b>April 19 49</b> to <b>30 Mar 1950</b> , that I last saw the deceased alive on <b>30 Mar 1950</b> and that death occurred at <b>8:55 pm.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Frank E. Dickman</b>		23b. ADDRESS <b>Independence Mo</b>	
23c. DATE SIGNED <b>11 Apr 50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>APRIL 1, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Indep. Mo.</b>
DATE REC'D BY LOCAL REG. <b>APRIL 3, 1950</b>	REGISTRAR'S SIGNATURE <b>Donald C. Earnshaw</b>	378	25. FUNERAL DIRECTOR'S SIGNATURE <b>Att &amp; Mitchell</b> ADDRESS <b>Indep. Mo</b>

(Licensed Embalmer's Statement on Reverse Side)

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

APR 14 1950

NO. 10000  
 STATE OF MISSOURI  
 DEPARTMENT OF HEALTH  
 DIVISION OF PUBLIC HEALTH  
 BUREAU OF VITAL STATISTICS  
 DEPARTMENT OF HEALTH  
 DIVISION OF PUBLIC HEALTH  
 BUREAU OF VITAL STATISTICS  
 DEPARTMENT OF HEALTH  
 DIVISION OF PUBLIC HEALTH  
 BUREAU OF VITAL STATISTICS

**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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Henry G. Mitchell

Licensed Embalmer No. 3925

P. O. Address Independence, 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.