

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37705

FILED DEC 4 1951
BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 431
State File No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town) INDEPENDENCE		c. CITY (If outside corporate limits, write RURAL and give township) R.R.#1 BLUE TOWNSHIP 0480	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) R.R.1 COURTNEY ROAD	
d. FULL NAME OF (If not in hospital or institution, give street address or location) INDEP. SANITARIUM			

3. NAME OF DECEASED (Type or Print) a. (First) HATTIE b. (Middle) ANDERSON c. (Last) MANN			4. DATE OF DEATH (Month) (Day) (Year) NOV. 11, 1951		
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5. SEX FE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH AUG. 31, 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) JACKSON COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME GEORGE ANDERSON		13b. MOTHER'S MAIDEN NAME JULIET STONE		14. NAME OF HUSBAND OR WIFE O.L.MANN (DEC'D)			
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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 Raymond Wiseman INDEP. 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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) auricular Fibrillation		
	DUE TO (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 11/6/51, 1951, to 11/11/51, 1951, that I last saw the deceased alive on 11/11/51, 1951, and that death occurred at 9:50 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. B. Miller, M.D.	23b. ADDRESS 310 S. Main	23c. DATE SIGNED 11/13/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 11/14/51	24c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.	24d. LOCATION (City, town, or county) (State) INDEPENDENCE, MO.
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DATE REC'D BY LOCAL REG. Nov 14-1951	REGISTRAR'S SIGNATURE James O. Ray	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS OTT & MITCHELL INDEP., MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 3156

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.