

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **24799**  
**3404**

No. 300  
10-48

FILED **JUL 24 1953**

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

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

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission.)	
a. COUNTY <b>JACKSON</b>	b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	a. STATE <b>MISSOURI</b>	b. COUNTY <b>JACKSON</b>
c. LENGTH OF STAY (in this place) <b>23 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BEVERLY NURSING HOME</b>		d. STREET ADDRESS (If rural, give location) <b>3429 LEXINGTON</b>	

<b>3. NAME OF DECEASED</b>		<b>4. DATE OF DEATH</b>	
a. (First) <b>ANNA</b>	b. (Middle) <b>LOUISE</b>	c. (Last) <b>FROST</b>	(Month) (Day) (Year) <b>JULY 6, 1953</b>
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>WIDOWED 2</b>	<b>8. DATE OF BIRTH</b> <b>SEPT. 22, 1864</b>
<b>9. AGE</b> (In years last birthday) <b>88</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>SWEDEN</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	

<b>13a. FATHER'S NAME</b> <b>JOHN LARSON</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>MARGARET ANDERSON</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>W.L. FROST</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	<b>16. SOCIAL SECURITY NO.</b> *****	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>MRS. PEARL ANDERSON</b>	<b>ADDRESS</b> <b>3429 LEXINGTON</b>
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<b>18. CAUSE OF DEATH</b> 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.	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pneumonia (Congestive)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>493X</b>
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b) Senility</b>		
	<b>DUE TO (c)</b> <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b> _____	<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> _____

**22. I hereby certify that I attended the deceased from June 1, 1953 to 7/6/1953, that I last saw the deceased alive on 7/6/53, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <b>James T. Ferguson, MD</b>	<b>23b. ADDRESS</b> <b>410 Bryant</b>	<b>23c. DATE SIGNED</b> <b>7/2/53</b>
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<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>24b. DATE</b> <b>JULY 9, 1953</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>FLORAL HILLS</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>KANSAS CITY, MISSOURI</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>7-8-53</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Rosalind Smith</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C.H. Blackman &amp; Son Inc.</b>	<b>ADDRESS</b> <b>9.C. M.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 W. C. Rinne

Licensed Embalmer No. 4879

P. O. Address St. C. 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.