FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005915
State File No.

520
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 17 yr 8
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital No. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
d. Is residence within limits of city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 408 E. 9th

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle):
c. (Last): Turner

4. DATE OF DEATH (Month) (Day) (Year): 1 - 28 - 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: 9-21-13
9. AGE (In years last birthday): 44
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): at home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Missouri
12. CITIZEN OF WHAT COUNTRY: U. S.

13a. FATHER'S NAME: Adolf Krause
13b. MOTHER'S MAIDEN NAME: Della Jones
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Record office Gen Hosp #1
ADDRESS:

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver — 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)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-18-58 *19*___, *to* 1-28-58, *19*___, *that I last saw the deceased alive on* 1-28, *19* 58, *and that death occurred at* 6:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B. I. Burns M.D.
23b. ADDRESS: General Hospital No. 1
23c. DATE SIGNED: 1-29-58

24a. BURIAL, CREMATION, REMOVAL (Specify): Anatomical
24b. DATE: 1-31-58
24c. NAME OF CEMETERY OR CREMATORY: Western Dental Coll.
24d. LOCATION (City, town, or county) (State): K.C. Mo

DATE REC'D BY LOCAL REG.: 1-31-58
REGISTRAR'S SIGNATURE: Neva Minshall
25. FUNERAL DIRECTOR'S SIGNATURE: B. F. Weifert
ADDRESS: K.C. 8 Mo

(Licensed Embalmer's Statement on Reverse Side)

B. I. Burns

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed B. E. Weilert

Licensed Embalmer No. 4

P. O. Address K.C.8.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.