

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017077

FILED MAY 29 1959

Registration District No. 393 Primary Registration District No. 1002 STATE FILE NUMBER 2235 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>3753 BRIARCLIFF</b> Length of stay in lb <b>30 YRS</b>		d. STREET ADDRESS (If outside, give location) <b>3753 BRIARCLIFF</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>A.</b> Last <b>ALDERMAN</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 4 1872</b>
9. AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b> Hours <b>6</b> Min.	IF UNDER 24 HRS Hours <b>6</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Smith Center KS.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13a. FATHER'S NAME <b>HENRY H. REED</b>	
13b. MOTHER'S MAIDEN NAME <b>AMANDA WELSH</b>		14. NAME OF HUSBAND OR WIFE <b>MASON C ALDERMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>DALLAS ALDERMAN 1251 W. 63 RD</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A. - Probable Hemorrhage.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Very short</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension &amp; Arteriosclerosis</b>			14 + years
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus -</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ p.m.		_____	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>8-4 1945</b> to <b>5-5-59</b> and last saw her/him alive on <b>April 16, 1959</b> Death occurred at <b>4 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul B. Leitz</b> (Degree or title) <b>MA</b>		22b. ADDRESS <b>1530 Prof. Bldg. Council Bluffs Mo</b>	22c. DATE SIGNED <b>5-5-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO</b>
24. FUNERAL DIRECTOR <b>D. W. Neucomis</b> ADDRESS <b>Some N.K.C.</b>		25. DATE RECD. BY LOCAL REG. <b>5-5-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

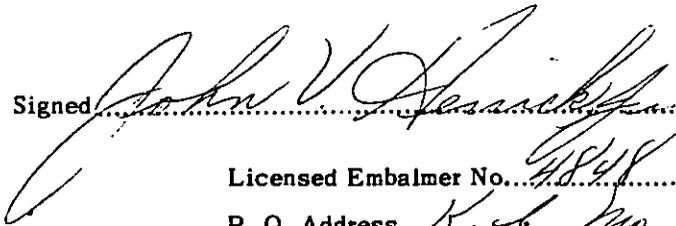
Health, welfare, public service, All diseases in Part I must be causally related. Frank B. Leitz

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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 .....  
Signature of Student Embalmer

Signed  .....  
Licensed Embalmer No. 4848 .....  
P. O. Address K. L. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.