

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034614

FILED VS. OCT 10 1960

149

Primary Registration District No. 1002

Registrar's No.

4774

STATE FILE NUMBER

INDEXED

| | | | | | | | | |
|---|--|---|--|--|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 30 yrs. | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 412 West 11th. st. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 412 West 11th. st. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CARL Middle - Last ANDERSON | | | | 4. DATE OF DEATH Month 9 Day 19 Year 60 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 1-1-71 | 9. AGE (last birthday) 89 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (City and state or country) ? ,Sweden | | 12. CITIZEN OF WHAT COUNTRY U.S.A. 1916 | | |
| 13a. FATHER'S NAME "unknown" | | | 13b. MOTHER'S MAIDEN NAME "unknown" | | | 14. NAME OF HUSBAND OR WIFE Maude E. Halbert Anders | | |
| 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. 496-07-5460 | | 17. INFORMANT Records: Jackson County Welfare, K.C., | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 _____ a.m. _____ p.m. | Month, Day, Year _____ | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Hugh H. Owens M.D. Coroner | | | | 22b. ADDRESS 152 Union Station - K.C., Mo. | | 22c. DATE SIGNED 9-20-60 | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | 23b. DATE 9-22-60 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | | | | |
| 24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES(S) K.C., MO. | | | | 25. DATE RECD. BY LOCAL REG. 9-20-60 | | 26. REGISTRAR'S SIGNATURE H. L. Dwyer | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Hugh H. Owens

EMAC

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. E. Willet

Licensed Embalmer No. 407

P. O. Address K.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.