

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-046737

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6638

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 14 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Jackson</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u> </u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u></p> <p>c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>1401 E 13th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>Isadora</u> Middle <u> </u> Last <u>Anderson</u></p>	
<p>4. DATE OF DEATH Month <u>December</u> Day <u>25</u>, Year <u>1962</u></p>	
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>Negro</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> <u>unk.</u> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>7 5 1928</u></p>
<p>9. AGE (last birthday) <u>34 yrs</u></p>	<p>IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>home</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>Bahama Islands</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u> </u></p>
<p>13a. FATHER'S NAME <u> </u> 13b. MOTHER'S MAIDEN NAME <u> </u> 14. NAME OF HUSBAND OR WIFE <u> </u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, np, or unknown) (If yes, give war or dates of service) <u>unknown</u></p>	
<p>16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Herford Funeral Home</u> Address <u>K.C. Mo.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Pre-eclampsia with cerebral hemorrhage</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u></p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u></p> <p style="text-align: right;">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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u></p>	
<p>20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u></p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u></p>
<p>20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u></p>	
<p>21. I attended the deceased from <u>12-25-62</u> to <u>12-25-62</u> and last saw her alive on <u>12-25-62</u></p> <p style="text-align: center;">Death occurred at <u>4:46 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE <u>Frank Ellis</u> (Degree or title) <u> </u></p>	<p>22b. ADDRESS <u>2400 Cherry</u></p>
<p>22c. DATE SIGNED <u>12-29-62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>12 31 1962</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u></p>	
<p>23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u></p>	
<p>24. FUNERAL DIRECTOR <u>C. K. Kerford</u> ADDRESS <u>K.C. MO.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>12-27-62</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>Ruth Long</u></p>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	DOCUMENT
1				
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BY AFFIDAVIT OF MEDICAL CERTIFICATION

JUN 4 1963

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 *Charles H. Hays*

Licensed Embalmer No. 4437

P. O. Address *R. C. M.*

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.