

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-001417

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 387

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

FILED FEB 6 1963 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. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 920 Cherry(home address)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula Ann Anderson		4. DATE OF DEATH January 21 1963	
5. SEX Female	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 3-3-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and state or country) Louisville, Kentucky		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Cal Brewer		13b. MOTHER'S MAIDEN NAME Lucy (unknown last name)	
14. NAME OF HUSBAND OR WIFE Alfred A. Anderson		17. INFORMANT Fern Grimes 15008 E 4th	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of No)		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Cerebral thrombosis			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) Chronic cerebral arteriosclerotic disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome			PART III. If deceased was female was there a pregnancy in last 90 days.
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 10-22-60 to 1-21-63 and last saw her/him alive on 1-21-63			
Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) D. M. Nigro M.D.		22b. ADDRESS 1222 McGee, Kansas City, Mo.	
22c. DATE SIGNED 1-22-63		23. NAME OF CEMETERY OR CREMATORY Olathe Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-24-63	
23c. LOCATION (City, town, or county) Olathe, Kansas		24. FUNERAL DIRECTOR Maubrey & Co. Olathe, Mo.	
25. DATE RECD. BY LOCAL REG. 1-22-63		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

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 Morris Rex Buell, Student Embalmer No. 690

working under my personal supervision.

Student

Morris Rex Buell
Signature of Student Embalmer

Signed

Ernest W. Dyer

Licensed Embalmer No.

3615

P. O. Address

Little Rock

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.