

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

16476

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Forty four days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Leean Anderson

3. (b) If veteran, name war r 3. (c) Social Security No. r

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Tillman Anderson
6. (c) Age of husband or wife if alive Unk years
7. Birth date of deceased November 5 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 18 hr. min.

9. Birthplace Howell County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name James Brewerton

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Winnie Francis

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Tillman Anderson

(b) Address Summersville Missouri

17. (a) Burial (b) Date thereof 5-23-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain View Mo.

18. (a) Signature of funeral director Charles L. Palmer

(b) Address Columbia Mo

19. (a) 5-23-47 (b) Mrs R.E. Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas
(c) City or town Summersville
(If outside city or town limits, write "RURAL")
(d) Street No. Route #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1947 hour 5 minute 30 a M.

21. I hereby certify that I attended the deceased from April 9, 1947, to May 23, 1947
that I last saw her alive on May 23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Leiomyosarcoma of the uterus with generalized metastases Duration 1 year

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature Cornelia S. Mottley (M. D. or other)
Address Ellis Fischel Cancer Hosp. Date signed 5-23-47
Columbia Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 5-27-47

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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