FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 13 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21473 7529

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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

1. PLACE OF DEATH:
(a) County
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. JOHNS HOSP. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS 96
(c) City or town KIRKWOOD 4
(If outside city or town limits, write "RURAL")
(d) Street No. 623 MCKINLEY AVE 3
(If rural, give location) N.R. 1
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SAMUEL J. ANDERSON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife HELEN E. ANDERSON
6. (c) Age of husband or wife if alive years
7. Birth date of deceased MAY 2, 1863 (Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 24 If less than one day hr. min.

9. Birthplace U.S.A. (City, town, or county) (State or foreign country)
10. Usual occupation PUBLIC SERVICE
11. Industry or business

MOTHER FATHER
12. Name ANDERSON
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant HELEN E. ANDERSON
(b) Address 623 McKINLEY AVE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-48 (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK
18. (a) Signature of funeral director M. J. Crayton
(b) Address 746 MANCHESTER
19. (a) AUG 27 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 26TH year 1948 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from 10 July, 1948, to 26 August, 1948; that I last saw him alive on 25th August, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis degenerative	
Due to: arteriosclerotic Heart Disease	
Due to: D.A.R.	
Other conditions: Prostatic Hypertrophy. (Include pregnancy within 8 months of death)	

Major findings:
Of operations
Of autopsy confirmed

PHYSICIAN — Underline the cause of which death should be charged statistically.

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

23. Signature Leo Bartels (M. D. or other) MD
Address 200 Frisco Bldg Date signed Aug 29 '48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side) LEO BARTELS

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.