

FILED JAN 11 1949 918

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH 1904

State File No. 11879  
Registrar's No. 11879

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days  
2 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4650 Page Blvd  
(If rural, give location)  
(e) Citizen of foreign country? 12 (Yes or No)  
If yes, name country

3: (a) PRINT FULL NAME Edward Anderson

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Emma Anderson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 6 1885  
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown Alabama  
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business \_\_\_\_\_

12. Name William Anderson

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

14. Maiden name Lottie Unknown

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

16. (a) Informant Emma Anderson

(b) Address 4650 Page

17. (a) Removal (b) Date thereof 12-16-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address 1721 Coleman St.

19. (a) DEC 16 1949 (b) J. B. Lanier  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 11  
year 1948 hour 11 minute 35 P. M.

21. I hereby certify that I attended the deceased from Dec. 3 19 48 to Dec. 11 19 48  
that I last saw him alive on Dec. 11 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Benign Hypertrophy of the Prostate; Pyelonephritis and Uremia

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Prostatic Calculi and Chronic Retention  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy No

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) Means of injury U

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 2801 N Whittier Date signed 12/13/48

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

MOTHER FATHER

*None*

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**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 *Wm. J. [Signature]*

Licensed Embalmer No. *4371*

P. O. Address. *1721 Calverton St.*

**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.**