

FILED MAR 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7902

BIRTH NO. _____		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 417		Registrar's No. 9	
1. PLACE OF DEATH a. COUNTY DEKALB				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY DEKALB 22			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLARKSDALE				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLARKSDALE			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		a. (First) WILLIAM		b. (Middle) DAVID		c. (Last) ANDERSON	
4. DATE OF DEATH		(Month) MAR.		(Day) 3		(Year) 1949	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JAN 2 1869	
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months		11. IF UNDER 1 YEAR Days		12. IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during preceding life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) STEWARTSVILLE MO. 6		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME JOHN W. ANDERSON		13b. MOTHER'S MAIDEN NAME MARY ANN SNEATHAN		14. NAME OF HUSBAND OR WIFE ANN ANDERSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS ANN ANDERSON CLARKSDALE MO			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)				36 hrs	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 2, 1949</u> , to <u>March 3, 1949</u> , that I last saw the deceased alive on <u>March 3, 1949</u> and that death occurred at <u>10 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE E. M. Reynolds M.D.		(Degree or title)		23b. ADDRESS Union St. Mo		23c. DATE SIGNED 3-5-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAR 5 1949		24c. NAME OF CEMETERY OR CREMATORY AMITY		24d. LOCATION (City, town, or county) (State) AMITY MISSOURI	
DATE REC'D BY LOCAL REG. 3-7-49		REGISTRAR'S SIGNATURE R. S. Darnell		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PILCHER FUNERAL HOME MAYSVILLE MO			

(Licensed Embalmer's Statement on Reverse Side)

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

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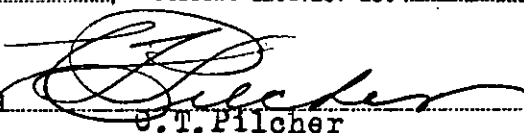
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

  
U.T. Pilcher

Signed.....  
Student Embalmer

Licensed Embalmer No. .... 3960

P. O. Address. .... Maysville Mo.

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.