

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

 State File No. **20721**
 Registrar's No. **4855**

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|---|---------------------------|--|--|---|---|--|---------------------|-----------------------------------|---|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | State File No. 20721 | | Registrar's No. 4855 | | | |
| 1. PLACE OF DEATH a. COUNTY St. Louis, Mo. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY _____ | | | | | | | |
| b. CITY OR TOWN St. Louis, Mo. | | c. LENGTH OF STAY (In this place) 30 yrs | | c. CITY OR TOWN St. Louis | | | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1. | | | | d. STREET ADDRESS (If rural, give location) 23-1514a So. 10th Street | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) MARGARET | | | b. (Middle) _____ | | | c. (Last) ANDERSON | | | 4. DATE OF DEATH (Month) (Day) (Year) June 2nd, 1949 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M | | 8. DATE OF BIRTH 1881 Oct. 9, 1885 | | 9. AGE (In years last birthday) 67 65 | 10. MONTHS 7 | 11. DAYS 23 | 12. HOURS & MIN. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | | 11. BIRTHPLACE (State or foreign country) Carleton, Illinois | | | 12. CITIZEN OF WHAT COUNTRY? _____ | | |
| 13a. FATHER'S NAME Lon Hall | | | 13b. MOTHER'S MAIDEN NAME Edna Lewis | | | 14. NAME OF HUSBAND OR WIFE William T. | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | | | 16. SOCIAL SECURITY NO. _____ | | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS William T. Anderson 1514a So. 10th St. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Ovary | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| 19a. DATE OF OPERATION June 3, 1949 | | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) H-9 | | | | | | | |
| 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? 175X | | | | | | | |
| 22. I hereby certify that I attended the deceased from 5/28/49 , 19____, to 6/2/49 , 19____, that I last saw the deceased alive on 6/2/49 , 19____, and that death occurred at 9:30am m., from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) William M. Loran, M.D. | | | | 23b. ADDRESS 1515 Lafayette Ave., | | | | 23c. DATE SIGNED 6/2/49 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 6-4-49 | | 24c. NAME OF CEMETERY OR CREMATORY City Cem. | | 24d. LOCATION (City, town, or county) (State) Greenfield, Illinois | | | | | |
| DATE REC'D BY LOCAL REG. JUN 3 1949 | | REGISTRAR'S SIGNATURE R. B. Losater | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Allen H. McLaughlin 2301 Lafayette | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student
Student Embalmer

Signed C W Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State File No. 20721-4

State of Mo. }
County of St. Louis } ss.

AFFIDAVIT FOR CORRECTION OF A RECORD

Local Registrar's No. 4855

On this 16th day of June, 1949, before me appears Mr. Wm. T. Anderson, who, upon his oath, states that the original record of death for Margaret Anderson, died ~~DECE~~ June 2, 1949, 19, in the State of Missouri, and which was filed at St. Louis, Mo. on June 3, 1949, should be corrected as follows:

Item No. 8 should read October 9, 1881

Instead of October 9, 1883

Item No. 9 should read 67

Instead of 65

Item No. should read

Instead of

The above is true to the best of my knowledge, information and belief.

(SEAL) Affiant: William T. Anderson Relationship.

1514 1/2 S. 10 St. Present Address.

Subscribed and sworn to before me this 14 day of June, 1949.

My Commission expires 3-4-53 Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

