

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22412**

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

BIRTH NO. _____		REG. DIST. NO. 1		PRIMARY REG. DIST. NO. 3000 Registrar's No. 223	
1. PLACE OF DEATH a. COUNTY Adair			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Adair		
b. CITY (If outside corporate limits, write RURAL and give township) Wicksville		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) Wicksville		3
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location) 903 S. Elston		
3. NAME OF DECEASED (Type or Print) a. (First) Frank		b. (Middle)		c. (Last) Anderson	
4. DATE OF DEATH (Month) (Day) (Year) July 30, 1949		5. SEX MO		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 2, 1893		9. AGE (In years last birthday) 56 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Operator		11. BIRTHPLACE (State or foreign country) Ivesdale, Ill	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME (Print) Tie die Anderson		13b. MOTHER'S MAIDEN NAME Gertrude (Unk)	
14. NAME OF HUSBAND OR WIFE Mabel Anderson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes. May 1918-1921		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Frank Anderson		17. ADDRESS Wicksville, Mo 903 S. Elston Ave		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) Medication	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Parkinsons Disease		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Encephalitis		INTERVAL BETWEEN ONSET AND DEATH Yes Yes	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) Homicide		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) m.		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 1944 , to 7/30 , 19 49 , that I last saw the deceased alive on July 6 , 19 49 , and that death occurred at 10 A m., from the causes and on the date stated above.					
23a. SIGNATURE Wm C Pluse		23b. ADDRESS (Degree or title) D. O. Wicksville, Mo		23c. DATE SIGNED 7/30/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/1/49		24c. NAME OF CEMETERY OR CREMATORY Nhoz City Cem	
24d. LOCATION (City, town, or county) Wicksville, Mo		25. FUNERAL DIRECTOR'S SIGNATURE Marley Travers		ADDRESS Wicksville, Mo	
DATE REC'D BY LOCAL REG. 7-30-49		REGISTRAR'S SIGNATURE Kate Lambert		ADDRESS Wicksville, Mo	

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District Health Officer No.
District File Number 8-49-13
Date Filed AUG 10 1949

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 Jon Marler

Licensed Embalmer No. 4430

P. O. Address Quincy City, Md

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.