

FILED JUL 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23957**

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

BIRTH NO. _____		REG. DIST. NO. <u>174</u>		PRIMARY REG. DIST. NO. <u>3035</u>		Registrar's No. <u>44</u>	
1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LEXINGTON</u> c. LENGTH OF STAY (in this place) <u>1 year</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>34th + South St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFAYETTE</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LEXINGTON</u> d. STREET ADDRESS (If rural, give location) <u>34th + South St. 71</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>IDA</u> b. (Middle) <u>ANDERSON</u> c. (Last) _____				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 26, 1949</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNE 12, 1869</u>	
9. AGE (In years last birthday) <u>79</u>		10. MONTHS <u>10</u>		11. DAYS <u>31</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>LEXINGTON, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>SAM SHAW</u>		13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES ANDERSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>FRANK ANDERSON</u> ADDRESS <u>LEX. MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Bronchitis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Poor living Conditions</u> DUE TO (c) <u>Old age</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>501X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Lexington Lafayette MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>April 1, 1949</u> , to <u>May 26, 1949</u> that I last saw the deceased alive on <u>May 24, 1949</u> , and that death occurred at <u>9 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>JO Coffey M.D.</u>				23b. ADDRESS <u>Lexington Mo.</u>		23c. DATE SIGNED <u>5/26/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAY 29, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MACHIE LAH</u>		24d. LOCATION (City, town, or county) (State) <u>LEXINGTON, MO</u>	
DATE RECD BY LOCAL REG. <u>6/26/49</u>		REGISTRAR'S SIGNATURE <u>Emmeline Forrest</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>FOREST, F. TEMPEL</u> ADDRESS <u>LEX. MO.</u>			

RECEIVED JUL 11

District Health Officer No. 8,

District File Number _____

Date Filed 7-15-49

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. 2983

P. O. Address Greenington Ave

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.