

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

No. 300  
10.48

FILED AUG 5 1949  
#79323

State File No. \_\_\_\_\_  
Registrar's No. **6572**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

|                                                                                                    |  |                                                                                                                                                  |  |
|----------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY <b>St. Louis</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richmond Heights</b>                                             |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>                         |  | d. STREET ADDRESS (If rural, give location) <b>P.R. = 1033 Claytonia</b>                                                                         |  |

|                                                                                                                  |  |  |                                                                 |  |  |
|------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>DON</b> b. (Middle) <b>Monroe</b> c. (Last) <b>ANDERSON</b> |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 28th, 1949</b> |  |  |
|------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------|--|--|

|                    |                               |                                                                        |                                       |                                           |                        |                      |                       |                      |
|--------------------|-------------------------------|------------------------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b> | 8. DATE OF BIRTH <b>July 27, 1890</b> | 9. AGE (In years last birthday) <b>59</b> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 MIN. Hours | IF UNDER 1 MIN. Min. |
|--------------------|-------------------------------|------------------------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------|----------------------|-----------------------|----------------------|

|                                                                                                                    |                                   |                                                              |                                          |
|--------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------|------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <b>Vienna, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b> |
|--------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------|------------------------------------------|

|                                          |                                              |                                                 |
|------------------------------------------|----------------------------------------------|-------------------------------------------------|
| 13a. FATHER'S NAME <b>James Anderson</b> | 13b. MOTHER'S MAIDEN NAME <b>Nancy Hopps</b> | 14. NAME OF HUSBAND OR WIFE <b>May Anderson</b> |
|------------------------------------------|----------------------------------------------|-------------------------------------------------|

|                                                                             |                                                                            |                                                                       |         |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Walter Smith, 1033 Claytonia</b> | ADDRESS |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------|---------|

|                                                                                                                                                                                                                               |                                                                                                                                                               |  |                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary TB</b>                                                                                    |  | INSET BETWEEN ANSWER AND DEATH<br><b>See above</b> |
|                                                                                                                                                                                                                               | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                                                    |
|                                                                                                                                                                                                                               | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |                                                    |

|                        |                                  |                                                                                     |
|------------------------|----------------------------------|-------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>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) <b>18</b> |
|------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------|

|                                                    |                                                                                                                   |                                       |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>02X</b> |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------|

22. I hereby certify that I attended the deceased from 7/18/49 1949, to 7/28/49, that I last saw the deceased alive on 7/28/49, and that death occurred at 8:20am from the causes and on the date stated above.

|                                              |                   |                                          |                                 |
|----------------------------------------------|-------------------|------------------------------------------|---------------------------------|
| 23a. SIGNATURE <b>John W. Humphrey, M.D.</b> | (Degree or title) | 23b. ADDRESS <b>1515 Lafayette Ave.,</b> | 23c. DATE SIGNED <b>7/28/49</b> |
|----------------------------------------------|-------------------|------------------------------------------|---------------------------------|

|                                                          |                          |                                    |                                                                    |
|----------------------------------------------------------|--------------------------|------------------------------------|--------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>7-28-49</b> | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) <b>- Vienna, Mo.</b> |
|----------------------------------------------------------|--------------------------|------------------------------------|--------------------------------------------------------------------|

|                                             |                                            |                                                          |         |
|---------------------------------------------|--------------------------------------------|----------------------------------------------------------|---------|
| DATE REC'D BY LOCAL REG. <b>JUL 29 1949</b> | REGISTRAR'S SIGNATURE <b>J. B. Pasater</b> | INSURANCE CARRIER'S SIGNATURE <b>Hopps, Crocker, Mo.</b> | ADDRESS |
|---------------------------------------------|--------------------------------------------|----------------------------------------------------------|---------|

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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Eleonore Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.