

FILED OCT 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33317

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 5291 Registrar's No. 72

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Clay</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Liberty</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Liberty</b>  |  |
| c. LENGTH OF STAY (in this place) <b>14 years</b>   |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State I.O.O.F. Hospital</b>                            |  | d. STREET ADDRESS (If rural, give location) <b>IOOF. Home</b>  |  |

|  |   |
|--|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Horatio</b><br>b. (Middle) _____<br>c. (Last) <b>Anderson</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Oct. 7-49</b> |
|--|---|

|                    |                               |   |                                    |   |                                    |                                   |                                 |                                |
|--------------------|-------------------------------|---|------------------------------------|---|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b> | 8. DATE OF BIRTH <b>May 5-1860</b> | 9. AGE (In years last birthday) <b>89</b> | IF UNDER 1 YEAR<br>Months <b>5</b> | IF UNDER 24 HRS.<br>Days <b>2</b> | IF UNDER 24 HRS.<br>Hours _____ | IF UNDER 24 HRS.<br>Min. _____ |
|--------------------|-------------------------------|---|------------------------------------|---|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|

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

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME <b>James Anderson</b> | 13b. MOTHER'S MAIDEN NAME <b>Lydia Flanders</b> | 14. NAME OF HUSBAND OR WIFE <b>No Record</b> |
|--|---|--|

|  |                                   |  |                            |
|--|-----------------------------------|--|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>No</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>IOOF Home Records</b> | ADDRESS <b>Liberty Mo.</b> |
|--|-----------------------------------|--|----------------------------|

|   |   |  |  |
|---|---|--|--|
| 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>Heart Arteriosclerosis</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>45.00</b> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Chronic Ulcerative Colitis</b><br><b>Cirrhosis of liver,</b><br>DUE TO (c) <b>Sclerosis of Coronary arteries</b> |  |  |
|   | 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? 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) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **1 P** m., from the causes and on the date stated above.

|   |                                |                                 |
|---|--------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Wm. G. Gadsden MD</b> | 23b. ADDRESS <b>Liberty Mo</b> | 23c. DATE SIGNED <b>10/9/49</b> |
|---|--------------------------------|---------------------------------|

|   |                             |   |  |
|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>Oct. 10-49</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>IOOF.</b> | 24d. LOCATION (City, town, or county) (State) <b>Liberty Mo.</b> |
|---|-----------------------------|---|--|

|  |   |    |  |                            |
|--|---|----|--|----------------------------|
| DATE REC'D BY LOCAL REG. <b>Oct. 9. 1949</b> | REGISTRAR'S SIGNATURE <b>William H. ...</b> | 64 | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Church, Decker Co.</b> | ADDRESS <b>Liberty Mo.</b> |
|--|---|----|--|----------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

24

RECEIVED OCT 24

District Health No. 8,

District File Number

Date Filed 10-24-49

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

Student Embalmer No.

working under my personal supervision.

Student Student Embalmer

Signed John S. Sander

Licensed Embalmer No. 444

P. O. Address Liberty 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.