

FILED NOV 30 1949

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH
State File No. 88311

|   |  |  |   |  |   |   |
|---|--|--|---|--|---|---|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>282</u> PRIMARY REG. DIST. NO. <u>5978</u>                   |   | Registrar's No. <u>151</u>                   |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Polk</u>  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u> |  |   |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Rural-Johnson Twp.</u>   |  | c. LENGTH OF STAY (in this place)<br><u>66 yrs</u>                             | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Rural-Johnson Twp.</u>                               |  | d. STREET ADDRESS (If rural, give location)   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION.<br><u>1</u>  |  |  | d. STREET ADDRESS (If rural, give location)   |  |   |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Mattie</u>  |  | a. (First)   | b. (Middle) <u>S.</u>   | c. (Last) <u>ANDERSON</u>                    | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Nov. 18-1949</u>                        |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>never married</u> | 8. DATE OF BIRTH<br><u>Oct. 28-1877</u>   | 9. AGE (In years last birthday)<br><u>72</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>20</u>                                      | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Keeping</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>                           | 11. BIRTHPLACE (State or foreign country)<br><u>Birkville, Ky.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                       |   |
| 13a. FATHER'S NAME<br><u>David C. Anderson</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Febie M. White</u>                             |   | 14. NAME OF HUSBAND OR WIFE<br><u>Single</u> |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  | 16. SOCIAL SECURITY NO.<br><u>—</u>  | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Lucy Anderson, Humansville, Mo.</u>    |   | ADDRESS<br><u>Humansville, Mo.</u>           |   |   |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death.   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u><br><br>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) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Reniculous anemia</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><u>7222</u><br><br><u>?</u>                 |   |
| 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)   |  |   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  | 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 <u>8/29</u> , 19 <u>47</u> , to <u>11/18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>49</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above. |  |  |   |  |   |   |
| 23a. SIGNATURE<br><u>S. M. Robinson</u>   |  | (Degree or title)<br><u>M.D.</u>   | 23b. ADDRESS<br><u>Humansville, Mo.</u>   |  | 23c. DATE SIGNED<br><u>11/18/49</u>   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   | 24b. DATE<br><u>Nov. 20-1949</u>   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Humansville Cem.</u>                  | 24d. LOCATION (City, town, or county) (State)<br><u>Humansville, Mo.</u>  |  |   |   |
| DATE REC'D BY LOCAL REG.<br><u>Nov. 21, 1949</u>  | REGISTRAR'S SIGNATURE<br><u>Ralph Gordon</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ed. H. Primm</u>   | ADDRESS<br><u>Humansville, Mo.</u>           |   |   |

(Licensed Embalmer's Signature on Reverse Side)

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

RECEIVED

District Health Officer No. 7,

District File Number 10-49-162

Date Filed 11-29-49

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**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.

Signed.....  
Student Embalmer

Signed

*Tom H. Northrop*

Licensed Embalmer No. 4747

P. O. Address Humansville, 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.