

FILED JUL 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20013

State File No.

BIRTH NO.		REG. DIST. NO. <u>140</u>		PRIMARY REG. DIST. NO. <u>3024</u>		Registrar's No. <u>74</u>	
1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette</u>		c. LENGTH OF STAY (If applicable) <u>5 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette</u> , <u>0451</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>200 Boyd St.</u>				d. STREET ADDRESS (If rural, give location) <u>200 Boyd</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>David</u>		b. (Middle) <u>Lee</u>		c. (Last) <u>Anderson</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>2</u> , (Year) <u>1950</u>	
5. SEX <u>Male</u> <u>0</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Never married</u>		8. DATE OF BIRTH <u>Sept. 3, 1944</u>	
9. AGE (In years last birthday) <u>5</u>		10. UNDER 1 YEAR <u>9</u> MONTHS <u>29</u> DAYS		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Missouri</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		13. FATHER'S NAME <u>Delore Gaylord Anderson</u>	
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME <u>Marie Grimes</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>D. G. Anderson</u> ADDRESS <u>Fayette, 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Multiple fractures Cervical Vertebrae</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Due fall from a tree</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>E9020</u> <u>21</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒ <u>045</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Fayette</u> , <u>Howard</u> , <u>Missouri</u>		21d. HOW DID INJURY OCCUR? <u>Fell from tree</u>	
21e. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 2 1950 5:00 P.</u>		21f. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒		22. I hereby certify that I attended the deceased from <u>July 2</u> , 19 <u>50</u> , to <u>July 2</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>50</u> , and that death occurred at <u>5:00 P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Francis D. Lee</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Lee Hospital, Fayette, Mo</u>		23c. DATE SIGNED <u>7-3-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>7/4/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fayette City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fayette</u> , <u>Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gale A. Carr</u> ADDRESS <u>Fayette, Mo</u>	
DATE REC'D BY LOCAL REG. <u>7-8-50</u>		REGISTRAR'S SIGNATURE <u>Mary K. Shell</u> <u>436</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gale A. Carr</u> ADDRESS <u>Fayette, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 7-10-50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 7-10-50

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, as follows

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....

Licensed Embalmer No. 3340

P. O. Address Fayette 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.