

FILED SEP 11 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

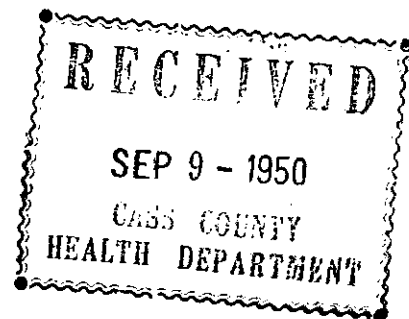
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State File No. \_\_\_\_\_

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| BIRTH NO. _____                                                                                                                                                                                                                                                   |  | REG. DIST. NO. <u>3</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | PRIMARY REG. DIST. NO. <u>4097</u>                                                                                                       |  | Registrar's No. <u>134</u>                                                                          |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cass</u>                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u> |  |                                                                                                     |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Harrisonville</u>                                                                                                                                                                 |  | c. LENGTH OF STAY (in this place) <u>4 hours</u>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>rural west Peculiar</u>                                  |  |                                                                                                     |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Harrisonville Hospital</u>                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | d. STREET ADDRESS (If rural, give location) <u>2 1/2 miles south Peculiar</u>                                                            |  |                                                                                                     |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>JOHN</u>                                                                                                                                                                                                     |  | b. (Middle) <u>LEONARD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | c. (Last) <u>ANDERSON</u>                                                                                                                |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 2, 1950</u>                                          |  |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                                                |  | 6. COLOR OR RACE <u>White</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>                                                                    |  | 8. DATE OF BIRTH <u>Sept. 15, 1913</u>                                                              |  |
| 9. AGE (In years last birthday) <u>36</u>                                                                                                                                                                                                                         |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>                                                                                        |  | 11. BIRTHPLACE (State or foreign country) <u>Lafayette Co., Mo.</u>                                 |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                                                                                                                                           |  | 13a. FATHER'S NAME <u>Leonard K. Anderson</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. MOTHER'S MAIDEN NAME <u>Gertrude Gillan</u>                                                                                         |  | 14. NAME OF HUSBAND OR WIFE <u>Luella Anderson</u>                                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>                                                                                                                                                                                       |  | 16. SOCIAL SECURITY NO. <u>✓</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. John Anderson</u> ADDRESS <u>Peculiar, 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, asthma, etc. It means the disease, injury, or complication which caused death.                                     |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL EDEMA, ACUTE</u><br><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>OXYCEPHALY, CONGENITAL</u><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>INFLUENZAL NASOPHARYNGITIS, ACUTE</u> |  |                                                                                                                                          |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 hrs.</u><br><u>36 Yrs.</u><br><u>7582</u><br><u>2 days</u> |  |
| 19a. DATE OF OPERATION <u>NONE</u>                                                                                                                                                                                                                                |  | 19b. MAJOR FINDINGS OF OPERATION _____                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</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>HARRISONVILLE, Cass, Missouri</u>                                                     |  | 21f. HOW DID INJURY OCCUR? _____                                                                    |  |
| 21d. TIME (Month) (Day) (Year) (Hour) _____ m.                                                                                                                                                                                                                    |  | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  |                                                                                                     |  |
| 22. I hereby certify that I attended the deceased from <u>Feb. 16, 1946</u> , to <u>Sept. 2, 1950</u> , that I last saw the deceased alive on <u>Sept. 1, 1950</u> , and that death occurred at <u>12:45 A m.</u> , from the causes and on the date stated above. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  |                                                                                                     |  |
| 23a. SIGNATURE <u>Herbert A. Tracy</u> (Degree or title) <u>M.D.</u>                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. ADDRESS <u>BELTON, Mo.</u>                                                                                                          |  | 23c. DATE SIGNED <u>9/3/50</u>                                                                      |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                           |  | 24b. DATE <u>Sept. 4, 1950</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Belton Cemetery</u>                                                                                |  | 24d. LOCATION (City, town, or county) (State) <u>Cass City, Missouri</u>                            |  |
| DATE REC'D BY LOCAL REG. <u>Sept 3, 1950</u>                                                                                                                                                                                                                      |  | REGISTRAR'S SIGNATURE <u>Rama J. Jones</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. K. George &amp; Sons</u> ADDRESS <u>Belton, Mo.</u>                                               |  |                                                                                                     |  |

(Licensed Embalmer's Statement on Reverse Side)

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



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 Embalmer No. ....

Signed \_\_\_\_\_

*Richard E. George*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3958

P. O. Address Benton, 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.