

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41756

FILED JAN 4 1951

State File No. _____
Registrar's No. 143

BIRTH NO. _____ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisiana		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisiana	
c. LENGTH OF STAY (In this place) 3 Weeks		d. STREET ADDRESS (If rural, give location) 218 D Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pike Co. Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) SPENCER	b. (Middle) ABRAHAM	c. (Last) ANDERSON	4. DATE OF DEATH (Month) (Day) (Year) DEC. 21, 1950
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 23, 1910	9. AGE (In years last birthday) IF UNDER 1 YEAR 40	IF UNDER 1 YEAR Months 7	IF UNDER 1 YEAR Days 28	IF UNDER 1 YEAR Hours 	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	10b. KIND OF BUSINESS OR INDUSTRY Janitor	11. BIRTHPLACE (State or foreign country) Pike Co., Missouri	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Abraham Anderson	13b. MOTHER'S MAIDEN NAME Nannie Scott	14. NAME OF HUSBAND OR WIFE Gerald Anderson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 489-26-8881	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Spencer Anderson, Louisiana, Missouri
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 MO
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Head of Pancrease		
	ANTECEDENT CAUSES C metastasis to liver Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 157X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **11-4, 1950** to **12-21, 1950**, that I last saw the deceased alive on **12-21, 1950**, and that death occurred at **9:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. R. Anderson Jr. MD	23b. ADDRESS Louisiana Mo	23c. DATE SIGNED 12-21-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/23/50	24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	24d. LOCATION (City, town, or county) (State) Louisiana, Missouri
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DATE REC'D BY LOCAL REG. Dec 23, 1950	REGISTRAR'S SIGNATURE Bernice Collier	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sterne Funeral Home, Louisiana, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

821
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JAN 17 1951

DEC 28 1950

Date Received:
DISTRICT HEALTH OFFICE #2
District File Number 12-50-2
Date Filed: DEC 28 1950

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.....
Student Embalmer

Signed *Virginia M. Sterne*

Licensed Embalmer No. *4645*

P. O. Address *Romana, 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.