

FILED JUN 4 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12172

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 382 PRIMARY REG. DIST. NO. 3037 Registrar's No. 64

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MO. b. COUNTY Oregon	
b. CITY OR TOWN Mt. Vernon		c. CITY OR TOWN Koshkongon 0750	
d. FULL NAME OF HOSPITAL OR INSTITUTION 615 E. Cherry		d. STREET ADDRESS Rural	
3. NAME OF DECEASED a. (First) William b. (Middle) JAKE c. (Last) ANDERSON			4. DATE OF DEATH (Month) (Day) (Year) MAY 25, 1951
5. SEX Male	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED widowed	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY laborer	11. BIRTHPLACE (State or foreign country) St. Louis, MO
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME UNKNOWN	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS PERRY Mosher Mt. VERNON
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Bronchiectasis & extreme Coughing. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio and mitral insufficiency 3 weeks DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arterio sclerosis.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No 526X	
20. AUTOPSY? 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) _____	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 June 1945, to May 25, 1951; that I last saw the deceased alive on May 25, 1951, and that death occurred at 11:57 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Stanley J. Haywood (Degree or title) M.D.		23b. ADDRESS Mt. Vernon, Mo.	
23c. DATE SIGNED May 26, 51			
24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	24b. DATE 5-27-51	24c. NAME OF CEMETERY OR CREMATORY Thayer	24d. LOCATION (City, town, or county) (State) Thayer, MO.
DATE REC'D BY LOCAL REG. May 27, 1951	REGISTRAR'S SIGNATURE Cecil Henderson 411	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MAX Fossett Mt. VERNON, MO.	

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

550  
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DIVISION OF HEALTH OF MD.  
District No. 5 - Springfield

RECEIVED MAY 29 1951

Dist. File 351-9226

Date Filed 5-29-51

**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 Gene C. Hunter

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4739

P. O. Address Republic, 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.