

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38644

318

1003

10801

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>10801</u>					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>9dys</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Agusta</u>		<u>6920</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>RR#1 Box 175</u>							
3. NAME OF DECEASED a. (First) <u>Alfred</u> (Type or Print)			b. (Middle) <u>Oscar</u>		c. (Last) <u>Anderson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 5, 1951</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 4, 1885</u>	9. AGE (In years last birthday) <u>66yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Principal St. Louis Public Schools</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Sioux City, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13a. FATHER'S NAME <u>Lautitz Anderson</u>			13b. MOTHER'S MAIDEN NAME <u>Gurine Gunderson</u>			14. NAME OF HUSBAND OR WIFE <u>Gena Berger Anderson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>500-30-4513</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Gena Anderson</u>				ADDRESS <u>R31 Box 175 A Agusta</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>		
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular Disease</u>							
				DUE TO (c) _____							
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____			19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		21d. (COUNTY) _____		21e. (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? <u>4-220</u>						
22. I hereby certify that I attended the deceased from <u>Sept. 21, 1946</u> , to <u>Dec. 5, 1951</u> , that I last saw the deceased alive on <u>Dec. 5, 1951</u> , and that death occurred at <u>1:25 a.m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>Clarence G. Mueller M.D.</u>					23b. ADDRESS <u>634 N. Grand Blvd.</u>			23c. DATE SIGNED <u>12-5-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Dec. 7, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sioux City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sioux City, Iowa</u>					
DATE REC'D BY LOCAL REG. <u>DEC 5 1951</u>		REGISTRAR'S SIGNATURE <u>Stan Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander & Sons</u>					ADDRESS <u>6175 Delmar</u>	

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

Dr. C. E. Mueller
No Theatre Body

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

Joseph E. McCulloch

Signed.....

Student Embalmer

Licensed Embalmer No. 2460

P. O. Address 61757 Edmar

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.