

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9874</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis</b>		<b>2239</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>				d. STREET ADDRESS (If rural, give location) <b>23 1715 So. 10 th St.</b>			
3. NAME OF DECEASED (Type or Print) <b>JAMES</b>		a. (First)		b. (Middle) <b>Mcafee</b>		c. (Last) <b>ANDERSON</b>	
4. DATE OF DEATH <b>NOV. 7 1951</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>9/5/16/1870</b>		9. AGE (In years last birthday) <b>81</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Cook</b>		11. BIRTHPLACE (State or foreign country) <b>West Holmes County Miss</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>Gatesworth Hotel</b>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Levi Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Sue Mcafee</b>		14. NAME OF HUSBAND OR WIFE <b>Maggie Young</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-07-3502</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mildred Bloominghorst Oakaville Ill.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lobar pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Diplococcal pneumonia</b>					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic heart disease 4 years</b>					
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) (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? <b>490X</b>			
22. I hereby certify that I attended the deceased from <b>11-2-51</b> , 19___, to <b>11-7-51</b> , 19___, that I last saw the deceased alive on <b>11-7-51</b> , 19___, and that death occurred at <b>4:45 A.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>John T. Lawton, M.D.</b>				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>11-7-51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>11/8/51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetary</b>		24d. LOCATION (City, town, or county) (State) <b>Oakaville Ill.</b>	
DATE REC'D BY LOCAL REG. <b>NOV 7 1951</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ambruster Mortuary 6633 Clayton Road</b>			

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.

Signed.....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed

*Ernest W. Spillars*

Licensed Embalmer No. *4080*

P. O. Address \_\_\_\_\_

EMBALMER in his OWN HANDWRITING. (Failure to comply with

Note: The above **MUST BE SIGNED BY THE LICENSED**  
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.