

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9625

State File No. ....

WED MAR 29 1952

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2209

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 21 2318 Cass 8	
3. NAME OF DECEASED a. (First) Charlene		c. (Last) Anderson	
4. DATE OF DEATH (Month) (Day) (Year) Mar. 5 1952		5. SEX 3 Female	
6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) No 0	
8. DATE OF BIRTH Jan. 23, 1950		9. AGE (In years last birthday) 2 IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME George Anderson		13b. MOTHER'S MAIDEN NAME Myrtle Harris	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mother, Myrtle Anderson, 2318 Cass	
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) Myelofibrosis INTERVAL BETWEEN ONSET AND DEATH 5 months ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined 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 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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 292.3		22. I hereby certify that I attended the deceased from 11-15, 1951, to 3-5, 1952, that I last saw the deceased alive on 3-5, 1952, and that death occurred at 6:36p m., from the causes and on the date stated above.	
23a. SIGNATURE M. D. M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 3-6-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	
24b. DATE Mar 9, 1952		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) St Louis		24e. (State) MO	
DATE REC'D BY LOCAL REG. MAR 8 1952		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. C. Green 4214 Selmer	

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.....

*F. A. Green*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.