

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4184

State File No.

FILED JAN 30 1953

BIRTH NO.		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>548</u>		Registrar's No. <u>0214</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>WEBSTER GROVES</u>		c. LENGTH OF STAY (in this place) <u>73 YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Blendale</u>		OR TOWN <u>WEBSTER GROVES</u> <u>4587</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>28 N ELM</u>				d. STREET ADDRESS (If rural, give location) <u>28 N ELM</u> <u>650</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle) <u>MARIE</u>		c. (Last) <u>ANDERSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-19-1953</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1-16-1866</u>		9. AGE (in years last birthday) <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>JAMES NISSEN</u>		13b. MOTHER'S MAIDEN NAME <u>MARIE DAHL</u>		14. NAME OF HUSBAND OR WIFE <u>H.C. ANDERSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no of unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Carl Anderson 28 N Elm</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</u>				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>And irregular fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO <u>Arteriosclerotic heart disease</u>				1 year			
DUE TO (c) <u>4200</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Hepatic necrosis, cause not known</u>							
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)		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 <u>1-17-</u> , 19 <u>53</u> to <u>1-19-</u> , 19 <u>53</u> that I last saw the deceased alive on <u>1-19-</u> , 19 <u>53</u> , and that death occurred at <u>m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. H. Goodrich M.D.</u>				23b. ADDRESS <u>19 E. Lockwood, Webster Groves 19, Mo.</u>		23c. DATE SIGNED <u>1-20-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-22-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>KIRKWOOD MO</u>	
DATE REC'D BY LOCAL REG. <u>1-21-53</u>		REGISTRAR'S SIGNATURE <u>H. H. Goodrich</u>		FURNERIAL DIRECTOR'S SIGNATURE <u>H. H. Goodrich</u>		ADDRESS <u>19 E. Lockwood, Webster Groves 19, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Leslie Malch

Licensed Embalmer No.

4395

P. O. Address

Whisper Groves

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.