

No. 300
10.48

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1000
1000

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

FILED MAR 13 1953

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Kansas b. COUNTY Middleton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Middleton	
c. LENGTH OF STAY (On this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospt.		e. ADDRESS	

3. NAME OF DECEASED (Type or Print) Harry LOroy Anderson			4. DATE OF DEATH 2-14-53		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Divorced	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) Approx. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (City and State or Foreign Country) Portland, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs. Patsey, Anderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Shirley Dean, Middleton, Con.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pulmonary Congestive				
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Broncho Pneumonia DUE TO (c) Acute Non Epidemic Meningitis (Fractured Rib)				
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) Natural		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.

23a. SIGNATURE Hugh Owens		23b. ADDRESS 1034 Rio Rio Bldg		23c. DATE SIGNED 2-16-53	
24a. BURIAL, CREMATION, OR OTHER DISPOSITION		24b. DATE 2-18-53		24c. NAME OF CEMETERY OR CREMATORIUM San Antonio Texas	
24d. LOCATION (City, town, or county) (State) San Antonio Texas					

DATE REC'D BY LOCAL REG. 2-17-53	REGISTRAR'S SIGNATURE Geraldine Smith	STATE HEALTH DEPARTMENT DIRECTOR'S SIGNATURE H. L. ...	ADDRESS H.C. ...
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(Licensed Embalmer's Statement on Reverse Side)

MAR 25 1953

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.....

Licensed Embalmer No.....

P. O. Address.....

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.