

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

13096

State File No. _____

FILED MAR 31 1953
BIRTH NO. 1999 2 REG. DIST. NO. 375 PRIMARY REG. DIST. NO. 6279 Registrar's No. 10

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

1. PLACE OF DEATH a. COUNTY <u>Wright</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wright</u>		
b. CITY OR TOWN <u>RURAL-GASCONADE</u>		c. LENGTH OF STAY (in this place) <u>1 yr</u>	c. CITY OR TOWN <u>RURAL-GASCONADE</u>		1140
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mansfield-R-3</u>			d. STREET ADDRESS (If rural, give location) <u>Mansfield-R-3</u>		
3. NAME OF DECEASED a. (First) <u>Virginia</u> b. (Middle) <u>Lee</u> c. (Last) <u>Anderson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 4, 1953</u>		
5. SEX <u>f</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>March 4, 1953</u>		9. AGE (in years last birthday) <u>1</u> if under 1 year: Months <u>1</u> Days <u>1</u> if under 28 hrs: Hours <u>1</u> Mins. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Mansfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Albert Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Remona Carbaugh</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or 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 <u>Albert Anderson, Mansfield, Mo.</u>		ADDRESS _____
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) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH _____
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Miscarriage</u>		
			DUE TO (c) <u>Ablatio Placenta (Unknown)</u>		
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) <u>7615</u> (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>6:15 PM 3/4, 1953</u> , to <u>7:15 PM 3/4, 1953</u> , that I last saw the deceased alive on <u>3/4, 1953</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>J. R. Gill</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>Seymour</u>		23c. DATE SIGNED <u>3/8/53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-6-53</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Wright, Mo. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3-16-53</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> 346-0		25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u> ADDRESS _____	

WRIGHT CO. HEALTH DEPT.
County File Number 353-43
Date Filed 3-20-23

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.