

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

23849

State File No.

BIRTH NO. FILED AUG 5 - 1953 REG. DIST. NO. 27 PRIMARY REG. DIST. NO. 3005 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY <u>Bates</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Butler</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Adrian</u>	
c. LENGTH OF STAY (in this place) <u>5 Da</u>		0070 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Butler Memorial Hospital</u>			
d. STREET ADDRESS (If rural, give location)			

3. NAME OF DECEASED (Type or Print) <u>Walter</u>		a. (First) <u>Walter</u>		b. (Middle) <u>H.</u>		c. (Last) <u>Anderson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 28, 1953</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 12, 1878</u>		9. AGE (In years last birthday) <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Market</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Nevada Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Andrew Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Olson</u>		14. NAME OF HUSBAND OR WIFE <u>Ada Anderson</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>492-38-7793</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ada Anderson, Adrian Mo.</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis following surgery for perforated duodenal ulcer</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</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 <u>5411</u>		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) m.		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 July 20, 1953 to July 28, 1953, that I last saw the deceased alive on July 28, 1953, and that death occurred at 1:00 p.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. E. Robinson M.D.</u>		23b. ADDRESS <u>Adrian Mo.</u>	
23c. DATE SIGNED <u>7-29-53</u>			

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-30-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Warrensburg Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Warrensburg Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>July 30 - 53</u>		REGISTRAR'S SIGNATURE <u>Kendall Rorick</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>L. J. Funeral Service Adrian Mo</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

AUG 17 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. 3650

P. O. Address Adrian Mo.

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.