

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **1149**BIRTH NO. **FILED FEB 15 1954** REG. DIST. NO. **1113** PRIMARY REG. DIST. NO. **4232** Registrar's No. **1149**

1. PLACE OF DEATH a. COUNTY H owell				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell			
b. CITY (If outside corporate limits, write RURAL and give township) Willow Springs,		c. LENGTH OF STAY (in this place) 43 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) Willow Springs,		0460	
d. FULL NAME OF HOSPITAL OR INSTITUTION X				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print) WILLIAM CHARLES ANSTINE				4. DATE OF DEATH (Month) (Day) (Year) 1-19-54			
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M		8. DATE OF BIRTH 6-25-1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R. R. Worker		10b. KIND OF BUSINESS OR INDUSTRY Frisco R. R.		11. BIRTHPLACE (State or foreign country) Macon County, Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME W. H. Anstine		13b. MOTHER'S MAIDEN NAME Mary Manhart		14. NAME OF HUSBAND OR WIFE Florence Kackley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. X		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Anstine, Willow Springs, Mo			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) DECOMPENSATION MYOCARDIAL WITH PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH ACUTE ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) HEMORRHAGE CEREBRAL 5 MONTHS 2. 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 331X		20. AUTOPSY? YES ☐ NO ☐			
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 ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/17 , 19 53 , to 1/19 , 19 54 , that I last saw the deceased alive on 1/18 , 19 54 , and that death occurred at 8:05 Am. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W. B. Perkins M.D.				23b. ADDRESS Willow Springs, Mo		23c. DATE SIGNED 1/28/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) B		24b. DATE 1-22-54		24c. NAME OF CEMETERY OR CREMATORY Homeland		24d. LOCATION (City, town, or county) (State) West Plains, Mo	
DATE REC'D BY LOCAL REG. FEB 15 1954		REGISTRAR'S SIGNATURE Ernie A. Bridges		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robertsons, West Plains, Mo			

(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

H. Roberts

Licensed Embalmer No. *3437*

P. O. Address

West Plains

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.