

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

3962

FILED MAR 1 1954

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>55</u>	
1. PLACE OF DEATH <u>ELLIS FISCALE STATE CANCER HOSP</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>BOONE</u>		a. STATE <u>MISSOURI</u>		b. COUNTY <u>NEWTON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>COLUMBIA</u>		c. LENGTH OF STAY (in this place) <u>16 days</u>		c. CITY OR TOWN <u>SENECA</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>ELLIS FISCALE STATE CANCER HOSP</u>				e. STREET ADDRESS (If rural, give location) <u>0730,</u>			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
<u>FLORENCE</u>		<u>Ethel</u>		<u>ANDERSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>19</u> <u>54</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>12-17-87</u>		9. AGE (in years last birthday) <u>66</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 4 HRS. Hours <u>2</u> Min.	
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>1</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>CASSVILLE Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>COLUMBUS A. MORGAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JANE KING</u>		14. NAME OF HUSBAND <u>WESLEY 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>—</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HOSPITAL RECORDS</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>Chronic lymphatic leukemia</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) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>2040</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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>9-29, 1950</u> , to <u>2-19, 1954</u> , that I last saw the deceased alive on <u>2-19, 1954</u> , and that death occurred at <u>5:50 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Richard E. Larson, M.D.</u>				23b. ADDRESS <u>Columbia, Mo</u>		23c. DATE SIGNED <u>2-19-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb. 20 1954</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Seneca Mo</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 20 1954</u>		REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer Funeral Home, Columbia, Mo</u>		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 1 1955

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.....  
Signature of Student Embalmer

Signed.....  
Thomas L. Baring

Licensed Embalmer No. 4123

P. O. Address Columbia

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.