

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7753

State File No.

BIRTH NO. FILED APR 5 1954 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 330

1. PLACE OF DEATH a. COUNTY <p align="center">Buchanan</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <p align="center">Missouri</p> b. COUNTY <p align="center">Buchanan</p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center">St. Joseph</p>	c. LENGTH OF STAY (in this place) <p align="center">25 years</p>	c. CITY OR TOWN <p align="center">St. Joseph</p>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center">Parkview Nursing Home 3225 So. 11th St.</p>		e. STREET ADDRESS (If rural, give location) <p align="center">R. R. #5</p>	

3. NAME OF DECEASED (Type or Print)	a. (First) <p align="center">Nancy</p>	b. (Middle) <p align="center">W.</p>	c. (Last) <p align="center">Anderson</p>	4. DATE OF DEATH (Month) (Day) (Year) <p align="center">March 19, 1954</p>
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5. SEX <p align="center">female</p>	6. COLOR OR RACE <p align="center">white</p>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <p align="center">never married</p>	8. DATE OF BIRTH <p align="center">November 18, 1865</p>	9. AGE (In years last birthday) <p align="center">88</p>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center">housework</p>	10b. KIND OF BUSINESS OR INDUSTRY <p align="center">own home</p>	11. BIRTHPLACE (City and State or Foreign Country) <p align="center">Virginia</p>	12. CITIZEN OF WHAT COUNTRY? <p align="center">USA</p>
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13a. FATHER'S NAME <p align="center">James Anderson</p>	13b. MOTHER'S MAIDEN NAME <p align="center">Rachel Debord</p>	14. NAME OF HUSBAND OR WIFE <p align="center">----</p>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p align="center">no</p>	16. SOCIAL SECURITY NO. <p align="center">none</p>	17. INFORMANT'S SIGNATURE OR NAME <p align="center">Mrs. Ella Sharp, R.R. #5, St. Joseph, Mo.</p>	ADDRESS <p align="center">-----</p>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Thrombosis</u>		<u>UNK.</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		<u>unk.</u> <u>unk.</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 <p align="center">332X</p>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Dec. 22, 1953, to Mar. 19, 1954, that I last saw the deceased alive on Jan. 26, 1954, and that death occurred at 2:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE <p align="center"><i>Sharon E. Waggner M.D.</i></p>	(Degree or title) <p align="center">M.D.</p>	23b. ADDRESS <p align="center">301 Illinois Ave. City</p>	23c. DATE SIGNED <p align="center">3-23-54</p>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center">burial</p>	24b. DATE <p align="center">3/21/1954</p>	24c. NAME OF CEMETERY OR CREMATORY <p align="center">Turner Cemetery</p>	24d. LOCATION (City, town, or county) (State) <p align="center">Buchanan County, Mo.</p>
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DATE REC'D BY LOCAL REG. <p align="center">Mar 27, 1954</p>	REGISTRAR'S SIGNATURE <p align="center"><i>Kathleen M. Allison</i></p>	25. FUNERAL DIRECTOR'S SIGNATURE <p align="center"><i>Heston Bowman</i></p>	ADDRESS <p align="center">St. Joseph, Mo.</p>
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(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.....
Signature of Student Embalmer

Signed *W. J. Edmonstone*.....

Licensed Embalmer No. *47*.....

P. O. Address *319 S. W. A.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.