

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8051**

FILED MAR '22 1954
BIRTH NO. _____ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **3012** Registrar's No. **28**

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Excelsior Springs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Excelsior Springs	
c. LENGTH OF STAY (in this place) 9 days		d. STREET ADDRESS (If rural, give location) 404 Salem Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION Excelsior Springs Hospital			

3. NAME OF DECEASED (Type or Print) PERLE ANDERSON			4. DATE OF DEATH (Month) (Day) (Year) Feb. 28, 1954			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 13, 1890	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 4 WKS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) Wellman, Iowa		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Charley Wahl		13b. MOTHER'S MAIDEN NAME Ella Bernard		14. NAME OF HUSBAND OR WIFE Floyd L. Anderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Floyd L. Anderson, 404 Salem Rd., Ex. Springs, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 8 days	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		ANTECEDENT CAUSES				years	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Chronic Nephritis				weeks	
		DUE TO (c) Arterio sclerosis				year	
II. OTHER SIGNIFICANT CONDITIONS		Carcinoma of Breast				1 1/2 years	
		Arthritis, Rheumatism				20 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221 H				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) 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 **1-10, 1952**, to **2-28, 1954**, that I last saw the deceased alive on **2-28, 1954**, and that death occurred at **6:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clarence B. Robinson, M.D.		23b. ADDRESS Excelsior Springs, Mo.		23c. DATE SIGNED 2/28/54	
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-2-54		24c. NAME OF CEMETERY OR CREMATORY Crown Hill	
DATE REC'D BY LOCAL REG. 3/10/54		REGISTRAR'S SIGNATURE Baroline Hutchings		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Claude Prichard, Excelsior Spr's, 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 Lindley K. Jarrman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.

20-5-5