

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10649**  
Registrar's No. **777**

FILED APR 7 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richmond Heights</b>		c. CITY OR TOWN <b>Richmond Heights</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>17 Yrs.</b>		e. STREET ADDRESS (If rural, give location) <b>38 Lake Forest</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>38 Lake Forest</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>DELIA</b>	b. (Middle)	c. (Last) <b>ANDERSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MAR. 27. 1954</b>
-------------------------------------	-------------------------	-------------	---------------------------	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 3. 1865</b>	9. AGE (In years last birthday) <b>89</b>	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 24 HRS. Hours	# UNDER 24 HRS. Min.
----------------------	-------------------------------	---	--------------------------------------	---	-----------------------	---------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Litchfield, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	--	---

13a. FATHER'S NAME <b>Thomas Mahoney</b>	13b. MOTHER'S MAIDEN NAME <b>Johanna Lynch</b>	14. NAME OF HUSBAND OR WIFE <b>John N. Anderson</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>W. Clinton Taylor</b>	ADDRESS <b>38 Lake Forest</b>
---	-------------------------------------	--	-------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3/23/54</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		<b>?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypotension</b> DUE TO (c) <b>Arterio-sclerotic Heart Dis.</b>		<b>?</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary Edema</b>		<b>3/24/54</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>42.00</b>	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)	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 **Jan 1950**, to **March 27, 1954**, that I last saw the deceased alive on **March 27<sup>th</sup> 1954**, and that death occurred at **2:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>August J. Wickman - M.D.</b>	23b. ADDRESS <b>4660 Maryland Ave</b>	23c. DATE SIGNED <b>3/29/54</b>
--	---------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Mar. 30. 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield, Ill.</b>
--	--------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>3/29/54</b>	REGISTRAR'S SIGNATURE <b>Herbert S. Tomke</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Stock Mortuary</b>	ADDRESS <b>889 S. Brentwood</b>
---	---	--	---------------------------------

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

Dr. Aug. Neuman  
4668 Maryland  
7221 Greenway

FD 8344  
DE 1030

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 *John J. Laine*

Licensed Embalmer No. *4668*  
P. O. Address *St. Louis*

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.