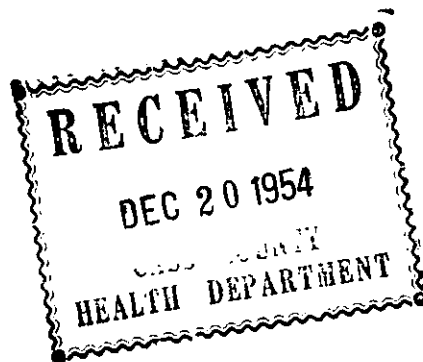


FILED DEC 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **40358**

BIRTH NO. _____		REG. DIST. NO. 59		PRIMARY REG. DIST. NO. 4097		Registrar's No. 197	
1. PLACE OF DEATH a. COUNTY Cass				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass			
b. CITY OR TOWN Harrisonville		c. LENGTH OF STAY (on this place) 3 days		c. CITY OR TOWN Harrisonville		d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital				e. STREET ADDRESS (If rural, give location) Suburban 019/0			
3. NAME OF DECEASED (Type or Print) a. (First) MYRTLE		b. (Middle) EFFIE		c. (Last) ANDERSON		4. DATE OF DEATH (Month) (Day) (Year) Dec 15 1954	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Apr 22 1888	
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State, or Foreign Country) Cass Co. Mo.	
12. CITIZENSHIP OF WHAT COUNTRY USA		13a. FATHER'S NAME Jack Hammonree		13b. MOTHER'S MAIDEN NAME Sarah Horton		14. NAME OF HUSBAND OR WIFE Robert C. 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 Hoel Anderson ADDRESS Stella 261			
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) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis 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 1 week Ho	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4-500				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) m.		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 12-10-1954 , to 12-15-1954 , that I last saw the deceased alive on 12-15-54 19____, and that death occurred at 12:20 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Edward S. Jones M.D.				23b. ADDRESS Harrisonville, Mo.		23c. DATE SIGNED 12-16-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec 17-1954		24c. NAME OF CEMETERY OR CREMATORY Orion Cemetery		24d. LOCATION (City, town, or county) (State) Harrisonville Mo.	
DATE REC'D BY LOCAL REG. Dec 16, 1954		REGISTRAR'S SIGNATURE 457-01 Dora Barrios		25. FUNERAL DIRECTOR'S SIGNATURE Penumburgas ADDRESS Harrisonville Mo.			

(Licensed Embalmer's Statement on Reverse Side)



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.....

James R. Phillips

Licensed Embalmer No..... 46

P. O. Address *Harrison*

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.