

FILED JUL 5 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19599**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 2522 Registrar's No. 175

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>60 yrs.</u>	c. CITY OR TOWN <u>Sedalia</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		STREET ADDRESS (If rural, give location) <u>915 South Ohio</u> <span style="float: right;">080%</span>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u>		b. (Middle) _____ c. (Last) <u>ANDERSON</u>	
4. DATE OF DEATH <u>June 27, 1955</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 5, 1879</u>	
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conductor</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Mo. Pacific Railroad Centertown, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Minerva Fletcher</u>	
14. NAME OF HUSBAND OR WIFE <u>Amelia 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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Amelia Anderson, Sedalia, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia.</u> <span style="float: right;">4 days.</span>  ANTECEDENT CAUSES <u>Cardio- Vascular Disease with Hypertension</u> <span style="float: right;">Over 5 years.</span>  DUE TO (b) <u>443X</u>  DUE TO (c) <u>Hypertrophy of the Prostate. 5 years/</u>  II. OTHER SIGNIFICANT CONDITIONS <u>Hypertrophy of the Prostate. 5 years/</u>  CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Medical treatment only.</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>	
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) <u>None.</u>		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>over 15 years</u> , 19 <u>June 27th, 1955</u> , that I last saw the deceased alive on <u>June 27th 55</u> and that death occurred at <u>12:10 PM</u> from the causes and on the date stated above.	
23a. SIGNATURE <u>Jno. B. Carlisle, M. D.</u> (Degree or title)		23b. ADDRESS <u>Sedalia, Missouri.</u>	
23c. DATE SIGNED <u>6-28-55</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>6/29/1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>		DATE REC'D BY LOCAL REG. <u>6-28-55</u> REGISTRAR'S SIGNATURE <u>J. B. Carlisle, M. D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Carlisle, M. D.</u>		ADDRESS <u>Sedalia, Mo.</u>	

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

JUL 28 1954

JUL 7 1954

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 *Russell C. Maag*

Licensed Embalmer No. ....  
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P. O. Address *Sedalia*

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