

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30543**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8526**

1. PLACE OF DEATH a. COUNTY <b>—</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>—</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>ST. LOUIS MO.</b>	c. LENGTH OF STAY (in this place) <b>40 Years</b>	c. CITY OR TOWN <b>ST. LOUIS</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>HOME →</b>		STREET ADDRESS (If rural, give location) <b>17 3125 ST. VINCENT</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>GARLAND</b> b. (Middle) <b>MORROW</b> c. (Last) <b>ANDERSON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT. 29 1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN 3 1895</b>
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LOCOMOTIVE ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>TENN.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>SAMUEL ANDERSON</b>	
13b. MOTHER'S MAIDEN NAME <b>KATY COOLEY</b>		14. NAME OF HUSBAND OR WIFE <b>VIOLA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>R.R.</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Viola Anderson</b>		ADDRESS <b>3125 S. Vincent.</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, asthenia, 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)		<b>MYOCARDIAL INFARCTION</b>		<b>1 DAY</b>	
ANTECEDENT CAUSES		DUE TO (b) <b>ARTERIOSCLEROSIS</b>		<b>MANY YEARS</b>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		<b>CEREBRAL THROMBOSIS, OLD</b>		<b>6 YRS.</b>	
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <b>NONE</b>		19b. MAJOR FINDINGS OF OPERATION <b>420.1</b>		20: AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>NO</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>— — —</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>— — —</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>—</b>	

22. I hereby certify that I attended the deceased from **SEPT 28, 1955**, to **SEPT. 29, 1955**, that I last saw the deceased alive on **SEPT 28, 1955**, and that death occurred at **2:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Charles H. Johnson, M.D.</b>		(Degree or title)		23b. ADDRESS <b>4148 FEDERER</b>		23c. DATE SIGNED <b>SEPT 29 '55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10-1-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 29 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLaughlin F.H., Inc., 2301 Lafayette</b>			

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 *James R. Chapman*  
Licensed Embalmer No. *45*  
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.