

FILED OCT 19 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33060**
4171

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City	c. LENGTH OF STAY (in this place) 2 yrs	c. CITY OR TOWN Kansas City	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 2618 Cleveland		e. STREET ADDRESS (If rural, give location) 2618 Cleveland	

3. NAME OF DECEASED (Type or Print) a. (First) Earl b. (Middle) Roscelle c. (Last) Anderson	4. DATE OF DEATH (Month) (Day) (Year) Sept 25, 1955
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5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 25, 1914	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) soner	10b. KIND OF BUSINESS OR INDUSTRY Swift Packing House	11. BIRTHPLACE (City and State or Foreign Country) South Park, Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Earl Sanders Anderson	13b. MOTHER'S MAIDEN NAME Iola Dolman	14. NAME OF HUSBAND OR WIFE Bernice Anderson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes	16. SOCIAL SECURITY NO. 495-01-3476	17. INFORMANT'S SIGNATURE OR NAME Bernice Anderson	ADDRESS 2618 Cleveland
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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 20 8:30 51
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diffuse Right side Subdural Hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diffuse Interstitial mediastinal Hemorrhage DUE TO (c) Shock.		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 2618 Cleveland	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson, MO.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-25-1955 8:00 A.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? don't know fell off porch
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE L. M. Tillman (Degree or title) Deput coroner	23b. ADDRESS 1618 Lydia Ave.	23c. DATE SIGNED 9/26/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Oct 1, 1955	24c. NAME OF CEMETERY OR CREMATORY Lincoln	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 9-27-55	REGISTRAR'S SIGNATURE Neva Minshall	25. FUNERAL DIRECTOR'S SIGNATURE Watkins Bros. Funeral Home	ADDRESS Clinton
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
L. M. Tillman

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 *Bruce A. Watkins*.....

Licensed Embalmer No. *452*.....

P. O. Address *18th Street*.....

**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.**