

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34539**
Registrar's No. **8990**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Missouri** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Saint Louis** c. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN **Saint Louis** d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **3727 Cass Avenue**
STREET ADDRESS (If rural, give location) **2811 N. Sarah Avenue**

3. NAME OF DECEASED a. (First) **William** b. (Middle) **M.** c. (Last) **Anderson**
4. DATE OF DEATH (Month) (Day) (Year) **Oct. 12, 1955**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **Dec. 15, 1895** 9. AGE (In years last birthday) **59** IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and State or Foreign Country) **St. Louis, Missouri** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Mathew Anderson** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Iolar Anderson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Yes WORLD WAR I** 16. SOCIAL SECURITY NO. **197-09-6191** 17. INFORMANT'S SIGNATURE OR NAME **Robert Anderson** ADDRESS **911 N. 15th St.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Pulmonary Congestion**
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) **Aortitis**
DUE TO (c) **Cardiac Hypertrophy**
II. 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 **434.3** 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) _____ 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:56 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE **Patricia C. Taylor Carver** 23b. ADDRESS **1300 Clark** 23c. DATE SIGNED **10.14.55**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **10-17-55** 24c. NAME OF CEMETERY OR CREMATORY **National Cemetery** 24d. LOCATION (City, town, or county) (State) **Jefferson Barrack, Mo.**

DATE REC'D BY LOCAL REG. **OCT 15 1955** REGISTRAR'S SIGNATURE **J. Carl Smith M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **5010 Enright Ave. Metropolitan Funeral System, Inc.**

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 *Paul V. Freeman*

Licensed Embalmer No. *476*

P. O. Address *4729 Ave*

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.