

FILED NOV 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36697

BIRTH NO.		REG. DIST. NO. 140		PRIMARY REG. DIST. NO. 3024		Registrar's No. 92			
1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howard					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN New Fayette lin		c. LENGTH OF STAY (in this place) 4 Days		c. CITY OR TOWN New Franklin		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Lee Hospital				e. STREET ADDRESS (If rural, give location) Route #1					
3. NAME OF DECEASED (Type or Print) a. (First) Clarence Denham Anderson b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 11 - 2 1955						
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 17, 1891		9. AGE (In years last birthday) 64	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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Boone County Missouri		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME William Anderson		13b. MOTHER'S MAIDEN NAME Heneretta Turner		14. NAME OF HUSBAND OR WIFE Lilian Anderson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-20-8998		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lilian Anderson, New Franklin, Mo.					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post-operative</u> DUE TO (c) <u>Generalized enteritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>none</u> <u>4 days</u> <u>2 days</u>	
19a. DATE OF OPERATION 10-29-55		19b. MAJOR FINDINGS OF OPERATION <u>Generalized enteritis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 <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 10-28, 1955, to 11-2, 1955, that I last saw the deceased alive on 11-2, 1955, and that death occurred at 10 ⁰⁰ A.M., from the causes and on the date stated above.									
23a. SIGNATURE <u>Wm J. Shaw M.D.</u>				23b. ADDRESS <u>Fayette, Mo.</u>		23c. DATE SIGNED <u>11-3-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/4/1955	24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Columbia, Missouri				
DATE REC'D BY LOCAL REG. 11-3-55		REGISTRAR'S SIGNATURE <u>Mary K. Bell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leman Funeral Home</u>		ADDRESS Columbia, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 20 1958

MAR 20 1958

JAN 6 1958

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 *Lynman T. Spunkle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia*

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