

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 18 1956

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 5003 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Morrow Twp.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Morrow Twp.</u>	
c. LENGTH OF STAY (in this place) <u>82 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>Route 1, Green Castle</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Home 7 mi. SE Green Castle</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Bryant</u> b. (Middle) <u>Wesley</u> c. (Last) <u>Anderson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9, 1956</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 14, 1883</u>	9. AGE (In years last birthday) <u>82</u>	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) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Bryant S. Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Ann Dupree</u>	14. NAME OF HUSBAND OR WIFE <u>Sarah Frances Anderson</u>
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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 ADDRESS <u>Mrs. Sarah F. Anderson, Green Castle</u>
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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, asthenia, etc. - It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Debular Heart Disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: _____ DUE TO (b) _____ DUE TO (c) _____	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4214</u>	

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION: _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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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? _____
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22. I hereby certify that I attended the deceased from July 1953, to Jan 9, 1956 that I last saw the deceased alive on Jan 7, 1956 and that death occurred at 7:00 p.m. from the causes and on the date stated above.

23a. SIGNATURE (of registrar or title) <u>A. W. Harrison, M.D.</u>	23b. ADDRESS <u>Springer Mo</u>	23c. DATE SIGNED <u>1-10-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1/12/1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cambell Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Adair Co., Mo.</u>
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DATE REC'D BY LOCAL REG. <u>1-12-56</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glenn E. Kent & Son, Green City, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
18

MAY 29 1956

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
Student Embalmer

Signed Earl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.