

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

State File No. **28067**  
**7577**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>3415 Hickory St.</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>William</b>	b. (Middle) <b>C.</b>	c. (Last) <b>Anderson</b>	(Month) <b>8</b>	(Day) <b>11</b>	(Year) <b>56</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov, 26, 1884</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS. Days <b>15</b>	Hours <b></b>	Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
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13a. FATHER'S NAME <b>Robert Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Madison</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>498-16-3054</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Marvell Anderson</b>		ADDRESS <b>3415 Hickory St.</b>	
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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, asthma, 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>Superior Mesenteric Artery Thrombosis</b>			<b>Undat.</b>	
ANTECEDENT CAUSES		<b>Gangrene, Small Intestine</b>				
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		<b>Benign Hypertrophy Prostate</b>				
Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>5702</b>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 **7-23**, 19 **56**, to **8-11**, 19 **56**, that I last saw the deceased alive on **8-11**, 19 **56**, and that death occurred at **3:10am** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Marble B. Herriford, M.D.</b>		23b. ADDRESS <b>2601 N. Whittier St.</b>		23c. DATE SIGNED <b>8-13-56</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug, 16, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
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DATE REC'D BY LOCAL REG. <b>AUG 15 1956</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wright Funeral Home 3100 Easton Ave.</b>			
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WRITE PLAINLY—USING UNFAADING 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 *Arthur L. Sullivan*.....

Licensed Embalmer No. *422*.....

P. O. Address *4107 3/2*.....

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.