

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30312

FILED OCT 1 - 1956

STATE FILE NUMBER

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 200

Health & Welfare
Public Service
300
1-56

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Warren</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Truxton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u> Length of stay in <u>4</u> days		d. STREET ADDRESS <u>none</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>George</u> Last <u>Anson</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1882</u>
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rural mail carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Service</u>	11. BIRTHPLACE (City and state or country) <u>Truxton, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nathaniel Anson</u>	
14. MOTHER'S MAIDEN NAME <u>Aurora Beck</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Oscar Anson, Warrenton, Mo.</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic pylo nephritis -</u> <u>Chronic cystitis ✓</u> DUE TO (b) <u>Chronic pylo nephritis</u> DUE TO (c) <u>acute myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>about 10 days</u> <u>5 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>9-11-56</u> to <u>9-22-56</u> and last saw her/him alive on <u>9-21-56</u> Death occurred at <u>12:05 a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wendell DeWolfe M.D.</u> (Degree or title)		22b. ADDRESS <u>Warrenton Mo</u>	
22c. DATE SIGNED <u>9-22-56</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>9-24-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anson Family Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Truxton, Mo.</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>F.W. Nieburg & Co., Warrenton, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>9/24/56</u>	
26. REGISTRAR'S SIGNATURE <u>W. J. Heidmann</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, ~~or by~~....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John J. Nieburg*.....

Licensed Embalmer No... 38

P. O. Address *Warrenton*

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

2.1.57