

FILED NOV 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39194**
10448
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10448	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (If this place) 6 wks		c. CITY OR TOWN Riverview		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital				e. STREET ADDRESS (If rural, give location) 9930 Jeffrey Dr.			
3. NAME OF DECEASED (Type or Print) a. (First) AMELIA			b. (Middle) _____		c. (Last) ANDERSON		4. DATE OF DEATH (Month) (Day) (Year) November 14th, 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH September 11th, 1894		9. AGE (In years last birthday) 62	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) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Louisville, Ky.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Schardein			13b. MOTHER'S MAIDEN NAME Julia Fitzpatrick		14. NAME OF HUSBAND OR WIFE Herbert 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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Herbert Anderson, 9930 Jeffrey Dr.,			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction - Postmyocardial						INTERVAL BETWEEN ONSET AND DEATH Sept 56
	ANTECEDENT CAUSES DUE TO (b) Coronary Artery - Atherosclerosis						3 yrs +
	DUE TO (c) General Arterio - Sclerosis						3 yrs +
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension - Essential						3 yrs +
	Cor Pulmonale -						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) (Minute) _____	
		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 May 21st, 1953 , to Nov 14, 1956 , that I last saw the deceased alive on Nov 14, 1956 , and that death occurred at 8:30 pm. , from the causes and on the date stated above.							
23a. SIGNATURE OF _____ (Degree or title) _____					23b. ADDRESS 8321 No Broadway		23c. DATE SIGNED 11/15/56
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 11/19/56		24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. NOV 15 1956		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DIEDRICH FUNERAL HOME, 8319 Hallsferry			

WRITE PLAINLY—USING UNFADEING 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 *Stanley H. Dixon*
Licensed Embalmer No. *419*
P. O. Address *S. P.*

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.