

FILED FEB 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3347

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 27	
1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SIKESTON</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Siikeston</u>		d. In 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 <u>SHUFFITT NURSING HOME</u>				e. STREET ADDRESS (If rural, give location) <u>115 Do rothy</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CARRIE</u>		b. (Middle) <u>PINETTE</u>		c. (Last) <u>ANDERSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-1-1957</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1-14-1884</u>	
9. AGE (In years last birthday) <u>73</u>		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>GULCONDA ILL.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>SAMUEL BONELL</u>		13b. MOTHER'S MAIDEN NAME <u>CHARLINA STEPHENSON</u>		14. NAME OF HUSBAND OR WIFE <u>HENRY ORSON ANDERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Adrian J. Anderson, Sikeston MO</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Cardiovascular disease</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>Generalized Hypertrophic Arthritis</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <u>3</u> 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)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>9-15</u> , 19 <u>56</u> , to <u>1-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Alfred J. Bargeant M.D.</u>		23b. ADDRESS <u>Sikeston MO</u>		23c. DATE SIGNED <u>2-9-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>2-3-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>	
DATE REC'D BY LOCAL REG. <u>2-11-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ollie Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welsh Funeral Home - Sikeston MO</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED

FEB 12 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No.

257-36

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

Raymond C. Crews

Licensed Embalmer No. 3467

P. O. Address

Sikeston, Mo.

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.