

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **16067**BIRTH NO. _____ REG. DIST. NO. **4** PRIMARY REG. DIST. NO. **5023** Registrar's No. **50**

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Atchison ✓	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Clay Twsp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Clay Twsp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION none		d. STREET ADDRESS (If rural, give location) none	
3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) Fredrick c. (Last) Andermann			4. DATE OF DEATH (Month) (Day) (Year) 5-22-1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9-20-1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Common Labor	11. BIRTHPLACE (State or foreign country) Hanover, Germany
12. CITIZEN OF WHAT COUNTRY? US		13a. FATHER'S NAME Fred Andermann	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Lou Andermann dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Guy Andermann		ADDRESS Rock Port.	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-Vascular Hemorrhage INTERVAL BETWEEN ONSET AND DEATH One Hour 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 Benign Prostatic Hypertrophy Conditions contributing to the death but not related to the disease or condition causing death. 2 YRS	
19a. DATE OF OPERATION Feb, 1957		19b. MAJOR FINDINGS OF OPERATION Benign Prostatic Hypertrophy.	
20. AUTOPSY? 2 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) 331x	
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 Jan. 27 , 1957, to May 22 , 1957, that I last saw the deceased alive on May 22 , 1957, and that death occurred at 9 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE James R. Allan, M.D. (Degree or title)		23b. ADDRESS Rock Port, Mo	
23c. DATE SIGNED 5-24-57		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 8-24-1957		24c. NAME OF CEMETERY OR CREMATORY Greenhill Cem.	
24d. LOCATION (City, town, or county) (State) Rock Port, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Bartholomew Mortuary, Rockport.	
DATE REC'D BY LOCAL REG. May 27, 1957		REGISTRAR'S SIGNATURE Therwin H. Schaefer	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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
Student Embalmer

Signed Gratz Bantolow

Licensed Embalmer No. 3173

P. O. Address Rock Port, 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 this body is not embalmed, fact should be so stated above.