FILED JUL 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 022322
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6166

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL Length of stay in this place: 16 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis Inside Limits Yes X No ☐
STREET ADDRESS (If outside, give location): 2516 Chester Ave. Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First DARRELL Middle WAYNE Last ANDERSON

4. DATE OF DEATH: Month JUNE Day 29 Year 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/20/1940

9. AGE (In years last birthday): 16 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): Student

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (City and state or country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond Anderson

14. MOTHER'S MAIDEN NAME: Elizabeth Hooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Elizabeth Anderson, 2516 Chester (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INTER -AURICULAR SEPTAL DEFECT — INTERVAL BETWEEN ONSET AND DEATH: SINCE BIRTH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 754.3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 JUNE 23, 1957, to JUNE 29, 1957 and last saw her/him alive on JUNE 29, 1957
Death occurred at 5:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. Vemillion M.D. (Degree or title) M.D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 6/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 7/5/57

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS: Charles J. Gates, 4107 Finney

25. DATE RECD. BY LOCAL REG.: JUL 2-'57

26. REGISTRAR'S SIGNATURE: Paul Smith MD
MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 18

P. O. Address 4107 Finn

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