FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 27306

Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 32

1. PLACE OF DEATH
a. COUNTY WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY WEBSTER
c. CITY OR TOWN MARSHFIELD 11 20 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 403 E. JACKSON — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First MERTIE Middle Last ANDERSON

4. DATE OF DEATH Month JULY Day 16 Year 1957

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH FEB 2 1884

9. AGE (In years last birthday) 73 — 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

11. BIRTHPLACE (City and state or country) MISSOURI

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME WILLIAM VAUGHN

13b. MOTHER'S MAIDEN NAME FRONIA GORDON

14. NAME OF HUSBAND OR WIFE LUTHER

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 LUTHER ANDERSON Address MARSHFIELD

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) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 8 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Hypertensive, arteriosclerotic cardiovascular disease — 15 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Diabetes Mellitus 443x

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 January 16, 1957, to July 16, 1957 and last saw her alive on July 16, 1957. Death occurred at 2:00 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. M. Macdonnell MD

22b. ADDRESS Marshfield, Mo.

22c. DATE SIGNED 20 July 57

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

23b. DATE 7-19-1957

23c. NAME OF CEMETERY OR CREMATORY MISSION HOME

23d. LOCATION (City, town, or county) (State) WEBSTER CO Mo

24. FUNERAL DIRECTOR ADDRESS BARBER-EDWARDS MARSHFIELD

25. DATE RECD. BY LOCAL REG. 7-23-57

26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

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.

S. 380 1-57

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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 embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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.