

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009786  
STATE FILE NUMBER  
1513

FILED APR 9 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1513

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gross Nursing Home</u>			Length of stay in 1b <u>12 yrs.</u>		d. STREET ADDRESS <u>6925 Edgevale</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Anderson</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 9, 1867</u>		9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Lewis Town, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Turner Scott</u>			13b. MOTHER'S MAIDEN NAME <u>Matilda Barber</u>		14. NAME OF HUSBAND OR WIFE <u>August W. Anderson (deceased)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Lawrence Hawkinson 6925 Edgevale</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerotic Cardio-Vasc. Disease.</u>						5 years.	
DUE TO (c) <u>Myocardial infarction; Dehydration; Post-operative anemia.</u>						4221	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the principal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>    </u>					
20c. TIME OF INJURY Hour <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>    </u>		20f. CITY, TOWN, OR LOCATION <u>    </u>		COUNTY <u>    </u>		STATE <u>    </u>	
21. I attended the deceased from <u>1952</u> to <u>3-22-58</u> and last saw her/him alive on <u>3-21-58</u> Death occurred at <u>6:50 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>463 S. Wyandotte, N.P. Mo</u>		22c. DATE SIGNED <u>3/23/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>March 23, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Calasburg, Illinois</u>		
24. FUNERAL DIRECTOR <u>Muehlebach</u>		ADDRESS <u>6800 Troost</u>		25. DATE REC'D. BY LOCAL REG. <u>3-23-58</u>	26. REGISTRAR'S SIGNATURE <u>Bevas Marshall</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

P. L. Byers

*copy of  
St. Andrew Hosp  
11/11/11*

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 *R.P. Meehan* .....

Licensed Embalmer No. *8997* .....

P. O. Address *U.C. 115* .....

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.