

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015213

STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 213

S. 300  
1-57  
804

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Dresden</b> 0 809 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>222 South Grand</b>		Length of stay in lb <b>1 month</b>	d. STREET ADDRESS (If outside, give location) <b>none</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ETTA</b> Last <b>ANDERSON</b>			4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1874</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Keytesville, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James W. Stevens</b>	
13b. MOTHER'S MAIDEN NAME <b>Margaret Cavanah</b>		14. NAME OF HUSBAND OR WIFE <b>James Lee Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, specify year or years of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Helen Rittman, 4143 Forest, Kansas City, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALNUTRITION</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CEREBRAL ARTERIO SCLEROTIC PSYCHOSIS</b>			334X
DUE TO (c) <b>SENILITY</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ANEMIA</b>			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.)
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>MARCH-21</b> to <b>DEATH</b> and last saw him live on <b>April 14 1958</b> Death occurred at <b>8:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Karl A. Souer MD</b> (Describe or title)		22b. ADDRESS <b>Sedalia Mo</b>	22c. DATE SIGNED <b>25 April 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/25/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dresden Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Dresden, Missouri</b>
24. FUNERAL DIRECTOR <b>Ernest Anderson</b> ADDRESS <b>Sedalia, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>4-25-1958</b>	26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *P. E. Baker* .....

Licensed Embalmer No. *2419* .....

P. O. Address *Seaside* .....

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.