

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021787  
STATE FILE NUMBER

FILED JUL 14 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3067

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City North</b> 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>Doctors Hospital</b>		Length of stay in lb <b>4 Years</b>	d. STREET ADDRESS (If outside, give location) <b>507 0 5444 North Cypress</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>NICOLAI W. ANDERSEN</b>			4. DATE OF DEATH Month Day Year <b>June 18th, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1907</b>
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Osteopathic Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Portland, Oregon</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James H. H. Andersen</b>	
13b. MOTHER'S MAIDEN NAME <b>Julia A. Thompson</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Dorothy J. Andersen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>553-20-1369</b>	
17. INFORMANT <b>Mrs. Dorothy J. Andersen</b>		Address <b>K.C. North, Mo. 5444 N. Cypress,</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>Coronary Artery Occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Obesity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>428</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 to 3 hours</b> <b>4 to 5 yrs.</b> <b>5 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.	
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>6-18-58</b> to <b>6-18-58</b> and last saw her alive on <b>6-18-58</b> Death occurred at <b>6:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>Roy V. Culp, D.O.</b>	
22b. ADDRESS <b>4840 Centennial Dr. B. B. Mo. 674</b>		22c. DATE SIGNED <b>6/19/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>June 21, 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>
23d. LOCATION (City, town, or county) <b>Portland, Oregon</b>		23e. (State) <b>OR</b>	
24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-20-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Roy V. Culp

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 Walter H. Curwin

Licensed Embalmer No. 4352

P. O. Address K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.