

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039795

STATE FILE NUMBER

NOV 19 1958

Registration District No. 149 Primary Registration District No. 1000 Registrar's No. 5213

300
1-57

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1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN PARKVILLE	
c. FULL NAME OF (If NOT in hospital, give name of HOSPITAL OR INSTITUTION) 2905 Forest		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH ANDERSON		4. DATE OF DEATH Month Day Year October 31, 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (City and state or country) Hamilton, Missouri		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Ed Anderson		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 375-12-2020		17. INFORMANT Address Mrs. Lucille Douglas Parkville, Missouri	
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>Cerebro-vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.) 201	
20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>Sept. 1958</u> to <u>10/30/58</u> and last saw ^{him} alive on <u>10/30/58</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>L. S. Daigle, M.D.</u> (Degree or title)		22b. ADDRESS <u>2122 Truman Rd</u>	
22c. DATE SIGNED <u>11/3/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-4-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkville</u>		23d. LOCATION (City, town, or county) (State) <u>Parkville, Missouri</u>	
24. FUNERAL DIRECTOR <u>Jatkins Bros. Funeral Home 18th & Benton</u>		25. DATE RECD. BY LOCAL REG. <u>11-4-58</u>	
26. REGISTRAR'S SIGNATURE <u>neva minshall</u>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

L. S. Daigle



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 *Ernest R. Watkins*

Licensed Embalmer No. *4500*

P. O. Address *18th & Benton*

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.