

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010378  
STATE FILE NUMBER

FILED MAR 23 1959 Registration District No. 274 Primary Registration District No. 3052N Registrar's No. 101

5. 300  
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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>Sedalia</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>		Length of stay in lb <b>3 weeks</b>	d. STREET ADDRESS <b>Star Route</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GARLAND</b> Middle <b>ANDERSON</b> Last <b>ANDERSON</b>			4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1908</b>		9. AGE (In years last birthday) <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Construction</b>		11. BIRTHPLACE (City and state or country) <b>Greenridge, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Elijah Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Melissa Williamson</b>		14. NAME OF HUSBAND OR WIFE <b>Laura Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Laura Anderson, Sedalia, Mo.</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>MYOCARDIAL FAILURE</b> DUE TO (b) <b>HYPERTENSION</b> DUE TO (c) <b>ACUTE NEPHRITIS</b> 590X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>(UREMIA) (PULMONARY EDEMA)</b>					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.)		
20c. TIME OF INJURY Hour _____ 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 <b>FEB 27 59</b> to <b>MARCH 16</b> and last saw him alive on <b>15 MARCH 59</b> Death occurred at <b>2:00</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Karl A. Gower MD</b>			22b. ADDRESS <b>Sedalia Mo</b>		22c. DATE SIGNED <b>17 March 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Longwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Longwood Missouri</b>
24. FUNERAL DIRECTOR <b>D. W. Heckart</b> ADDRESS <b>Sedalia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>March 18 1959</b>		26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>

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 *D. L. Shaffer* .....

Licensed Embalmer No. *5063* .....

P. O. Address *Bedford, N.H.* .....

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.