Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-010434
STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 43

1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. COUNTY: PIKE	a. STATE: MISSOURI b. COUNTY: PIKE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): LOUISIANA — Inside Limits: Yes [X] No [ ]	c. CITY OR TOWN: ASHBURN — Inside Limits: Yes [✓] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): PIKE COUNTY HOSPITAL — Length of stay in 1b: 14 DAYS	d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes [ ] No [✓]

3. NAME OF DECEASED (Type or print) — First: OLAF Middle: WILLIAM Last: ANDERSON

4. DATE OF DEATH — Month: MAR Day: 29 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: JULY 25-1900

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: AGRICULTURE

11. BIRTHPLACE (City and state or country): 1 MILE WEST ASHBURN, MO.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: OLAF ANDERSON

13b. MOTHER'S MAIDEN NAME: CLARA BENSON

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.: 494-20-6248

17. INFORMANT — Address: WILLIAM L. ANDERSON, ASHBURN, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 1621

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. — Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 Oct 1958, to Mar 1959 and last saw him alive on Mar. 29 1959
Death occurred at 5 PM. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. P. Hansen D.O.

22b. ADDRESS: Frankford Mo.

22c. DATE SIGNED: 3-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 3-31-59

23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEM.

23d. LOCATION (City, town, or county): PIKE COUNTY (State): MO

24. FUNERAL DIRECTOR — ADDRESS: GEO. M. COLLIER, LOUISIANA, MO.

25. DATE RECD. BY LOCAL REG.: Apr 2 1959

26. REGISTRAR'S SIGNATURE: Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

J/S APR 21 1959
MAY 4 1959

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 Geo. M. Collier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.