

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010667
STATE FILE NUMBER
2438

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED MAR 25 1959

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN East St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 870 N. 76th St.	
Length of stay in lb 2 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Virgil M. Anderson			4. DATE OF DEATH Month Day Year March 8, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1921	9. AGE (In years less birthday) 37	IF UNDER 1 YEAR Months Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Eolia, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME B. J. Anderson		13b. MOTHER'S MAIDEN NAME Jerusha Hurst		14. NAME OF HUSBAND OR WIFE Eileen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) (If yes, state war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Eileen Anderson, 870 N. 76th, E. St. Louis, Ill.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis			INTERVAL BETWEEN ONSET AND DEATH 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Ulcerative Colitis		2 years
	DUE TO (c) 572.2		
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 <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 7-8-59	
21. I attended the deceased from 3/7/59 to 3/8/59 and last saw ^{her} _{him} alive on 7:45 a.m. Death occurred at 7:45 am on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) Alan Mc Caffee M.D.		22b. ADDRESS 100 N Euclid Ave		22c. DATE SIGNED 7/9/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-11-59		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
				23d. LOCATION (City, town, or county) (State) Hannibal, Mo.	

24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. MAR 9 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	
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Admitted to St. Luke's Hospital 3/6/59 4:20 pm
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 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 *Laurance O. Galbraith*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis, 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.