

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014397  
STATE FILE NUMBER

FILED APR 23 1959 Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <b>PIKE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LOUISIANA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY <b>221 GRIFFITH St</b> TOWN <b>LOUISIANA</b>
FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PIKE COUNTY HOSPITAL</b>		Length of stay in lb <b>SINCE 1918</b>	d. STREET ADDRESS (If outside, give location) <b>LOUISIANA</b>
3. NAME OF DECEASED (Type or print) First <b>ROSIE</b> Middle <b>ANNA</b> Last <b>ANDERSON</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>1959</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 20 1872</b>
9. AGE (In years last birthday) <b>86.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (City and state or country) <b>MONTEGOMERY CITY MO</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13a. FATHER'S NAME <b>ISRAEL BUTLER.</b>		13b. MOTHER'S MAIDEN NAME <b>AMANDA WILBURN</b>	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) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS NELLIE POTTER</b> Address <b>LOUISIANA 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>Broncho-pneumonia. Pyleo-nephritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
DUE TO (b) <b>Arteriosclerotic cardio-vascular disease with general debility.</b>			<b>5 yrs.</b>
DUE TO (c) <b>Comminuted subcapital fracture of right humerus</b>			<b>17 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>9040 21</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>patient fell in home and hurt right shoulder</b>	
20c. TIME OF INJURY Hour <b>3-29-59</b> a.m. <b>p.m.</b>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Louisiana</b> COUNTY <b>Pike</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>10/18/54</b> to <b>4/14/59</b> and last saw her/him alive on <b>4/14/59</b> Death occurred at <b>11:30P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Chas. H. Lueder</b> (Degree or title) <b>M.B.</b>		22b. ADDRESS <b>Louisiana, Missouri</b>	
22c. DATE SIGNED <b>4-16-59</b>		22d. DATE OF DEATH	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 16, 1959</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW CEMETARY</b>		23d. LOCATION (City, town, or country) (State) <b>LOUISIANA MO</b>	
24. FUNERAL DIRECTOR <b>COZZIER FUNERAL HOME</b> ADDRESS <b>LOUISIANA</b>		25. DATE RECD. BY LOCAL REG. <b>April 18-59</b>	
26. REGISTRAR'S SIGNATURE <b>Bernice Collier</b>			

(Licensee's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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300  
-57

40

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. Callier*

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.