Health, Welfare Public Service

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1-57

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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

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-018895
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 4984

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3929 Cottage — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Noah		Andersen	5	20	59

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male 2	Negro 2	MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	May 5, 1866	92				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Minister		Utich, Miss. 1	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Allen Andersen	Unknown	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	—	Sam Reach	3114a Rutger

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerosis — undet.

DUE TO (c) 332x

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

Diverticulosis Coli

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ] 1

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 4-15-59, to 5-20-59 and last saw him alive on 5-20-59. Death occurred at 2:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. A. Fraser (Degree or title) M.D.

22b. ADDRESS 2601 Whittier Street

22c. DATE SIGNED 5-22-59

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

23b. DATE 5/25/59

23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery

23d. LOCATION (City, town, or county) St. Louis Co. (State) Mo.

24. FUNERAL DIRECTOR Metro. Funeral System. ADDRESS 5010 Enright

25. DATE RECD. BY LOCAL REG. MAY 22 '59

26. REGISTRAR'S SIGNATURE Noal Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 John K. Cunningham
Licensed Embalmer No. 4476
P. O. Address 2405 Marcus

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.