

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022643

STATE FILE NUMBER

2 5858

FILED JUL 13 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5218 Minerva		d. STREET ADDRESS (If outside, give location) 5218 Minerva	

3. NAME OF DECEASED (Type or print) First: Isaiah Middle: _____ Last: Anderson			4. DATE OF DEATH Month: _____ Day: 18 Year: 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4-1887	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months: _____ Days: _____
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Greenville Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Isaiah Anderson		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mary Anderson	
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. _____	17. INFORMANT Mary Anderson 2106 Missouri 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) Arterio sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arterio sclerosis		
DUE TO (c) 420.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		

20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE Patricia Taylor Carson		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 6-20-59	
23a. BURIAL, CREMATION, etc. (Specify) Removal		23b. DATE 6-22-59		23c. NAME OF CEMETERY OR CREMATORY Father Dickson	
23d. LOCATION (City, town, or county) St. Louis Co.				(State)	

24. FUNERAL DIRECTOR Wade Funeral Home 4202 Finney		25. DATE RECD. BY LOCAL REG. JUN 20 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with be listed. 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 *Edward A. Flynn*

Licensed Embalmer No. *4444*
P. O. Address *St. Louis*

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.