

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024630

FILED JUL 16 1959

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 50

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u>		Length of stay in 1b <u>16 yrs</u>		c. CITY OR TOWN <u>Salem</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home on West Park</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>West Park</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>Marquette</u> Middle <u>Anderson</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1959</u>															
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-86</u>		9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (City and state or country) <u>Iron Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>												
13a. FATHER'S NAME <u>John Pryor Woods</u>				13b. MOTHER'S MAIDEN NAME <u>Emily Ann Lucas</u>				14. NAME OF HUSBAND OR WIFE <u>Wm Henry Anderson</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT Address <u>Janie Mooney Salem Mo</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial failure</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input 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 <u> </u> Month, Day, Year <u> </u>		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	
21. I attended the deceased from <u>1940</u> to <u>7-11-59</u> and last saw her <u>7-7-59</u> alive on <u> </u> Death occurred at <u>1:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.										22a. SIGNATURE <u>Janie Mooney</u> (Degree or title) <u>DD.</u>		22b. ADDRESS <u>Salem, Mo.</u>				22c. DATE SIGNED <u>7/11/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-13-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Fork Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Reynolds Co Mo</u>											
24. FUNERAL DIRECTOR <u>Snencer Funeral Home Inc</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7/11/59</u>		26. REGISTRAR'S SIGNATURE <u>M. M. Nash, M. D. Lee</u>											

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Orlando P. Pinner

Licensed Embalmer No. *232*

P. O. Address *Palmer*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.