

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028204

FILED VS SEP 14 1959

042

Primary Registration District No.

1000

Registrar's No.

916

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>13 days</i>		c. CITY OR TOWN <i>Easton</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Methodist Hosp.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>-</i> Last <i>Anderson</i>						4. DATE OF DEATH Month <i>Sept.</i> Day <i>8,</i> Year <i>1959</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>8-15-1887</i>		9. AGE (last birthday) <i>72</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Osborne Co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>				
13a. FATHER'S NAME <i>John Wm Boyer</i>			13b. MOTHER'S MAIDEN NAME <i>Harriett Williams</i>			14. NAME OF HUSBAND OR WIFE <i>Robert L. Anderson</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>no.</i>		17. INFORMANT <i>Robert L. Anderson, Easton, Mo</i>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)		<i>Pseudomembranous Shistosoma coli Ti</i>						<i>36 hrs</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		<i>Abdomino-perineal resection</i>				<i>6 days</i>			
		DUE TO (c)		<i>Carcinoma of recto sigmoid</i>				<i>?</i>			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <i>5:30</i> Month, Day, Year <i>Aug 25, 1959</i>		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 <i>St Joseph Mo</i>		COUNTY <i>Buchanan Co. Mo.</i>		STATE	
21. I attended the deceased from <i>Aug 25, 1959</i> to <i>Sept 8, 1959</i> and last saw her alive on <i>Sept 8, 1959</i> Death occurred at <i>5:30</i> <i>p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <i>J.E. Senor M.D.</i>						22b. ADDRESS <i>St Joseph Mo</i>		22c. DATE SIGNED <i>9-9-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-10-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Freesman Chapel</i>		23d. LOCATION (City, town, or county) <i>Buchanan Co. Mo.</i>		(State)			
24. FUNERAL DIRECTOR <i>W.E. Summersfield, Stewartsville Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>Sept. 10, 1959</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>					

DOCUMENT

BY AFIDAVIT OF MEDICAL CERTIFICATION  
*J.E. Senor M.D.*

BY AFIDAVIT OF

AUG 23 1962

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 W E Summersfield

Licensed Embalmer No. 3607

P. O. Shewaitzville

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.