

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-032829

FILED VS OCT 15 1959

Registration District No. 160 Primary Registration District No. 5592 Registrar's No. 147

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>JEFF</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Festus</b>		Length of stay in 1b		c. CITY OR TOWN <b>DE SOTO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mountain View Convalescent</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>322 W. CLEMENT</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Tillie</b> Middle <b>MARY</b> Last <b>MATIDA Andrus</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>4</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"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19, 1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR. Days	IF UNDER 24 HR. Hours	IF UNDER 24 HR. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>IRON MOUNTAIN, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13a. FATHER'S NAME <b>NATHAN KERNELL</b>			13b. MOTHER'S MAIDEN NAME <b>ELIZ SCHNEIDER</b>			14. NAME OF HUSBAND OR WIFE <b>C. W. ANDRUS</b>				
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>unk</b>		17. INFORMANT <b>NELL WATSON</b> Address <b>DE SOTO, 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>Cardio Vasector Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>WORE 2 WKS</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis, Generalized</b>						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 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 _____ a.m. _____ p.m.		Month, Day, Year								
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 <b>7-20-59</b> to <b>10-4-59</b> and last saw her/him alive on <b>10-4-59</b> Death occurred at <b>4:35 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>M. D. [Signature]</b> (Degree or title)				22b. ADDRESS <b>Crystal City, Mo.</b>				22c. DATE SIGNED <b>10-5-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/6/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>			23d. LOCATION (City, town, or county) <b>DE SOTO</b>		(State) <b>MO</b>		
24. FUNERAL DIRECTOR <b>MAHN Funeral Home</b> ADDRESS <b>De Soto Mo</b>			25. DATE RECD. BY LOCAL REG. <b>10/6/59</b>		26. REGISTRAR'S SIGNATURE <b>John N. Hall, Deputy</b>					

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 Gerald J. Ma

Licensed Embalmer No. 4978

P. O. Address De Soto

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.