

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH						59-033431	
FILED VS SEP 21 1959				3058		217	
Registration District No. 210				Primary Registration District No.		Registar's No.	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		St. Charles		a. STATE		b. COUNTY	
				Missouri		St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Length of stay in 1b		c. CITY OR TOWN		Inside Limits	
St. Charles				Portage des Sioux		Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location)		Inside Limits		d. STREET ADDRESS		Reside on Farm	
St. Joseph Hosp		Yes ☒ No ☐		R. R. # 1		Yes ☐ No ☒	
3. NAME OF DECEASED				4. DATE OF DEATH			
First Middle Last				Month Day Year			
Glennon Anderson				Sept. 14, 1959			
5. SEX		6. COLOR OR RACE		7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐		8. DATE OF BIRTH	
Male		White				Sept. 13, 1959	
						0 Months 0 Days 2 Hours Min.	
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	
none		none		St. Charles, Mo.		U.S.A.	
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Donald Anderson				Dorothy Willis		none	
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				None		Sioux, Mo. Donald Anderson, Portage des	
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) <u>Toxemia Malnutrition</u>							
DUE TO (b) <u>Toxemia of Pregnancy</u>							
DUE TO (c) _____							
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.	
						☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		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 <u>9-13-59</u> to <u>9-14-59</u> and last saw him alive on <u>9-13-59</u>				Death occurred at <u>12:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE		(Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
<u>Dr. J. H. Wilson</u>		<u>MD</u>		<u>St Charles Mo</u>		<u>Sept 14 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Sept. 15, 1959		St. Francis Cemetery		Portage des Sioux, Mo.	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
H.C. Dallmeyer & Sons, St. Charles, Mo.				Sept 15-59		<u>Maureen Wilson</u>	

ENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Body not embalmed
Fred J. Amalony

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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