

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

59-033519

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8196** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
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 8 & Pine St Mark Twain Hotel		d. STREET ADDRESS 118 N. 8th St. 8 & Pine St	

3. NAME OF DECEASED (Type or print) First Robert I. Middle H Last Anderson			4. DATE OF DEATH Month Sept. Day 3 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/7/86	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jackson, Tenn.	
13a. FATHER'S NAME Gilbert Anderson		13b. MOTHER'S MAIDEN NAME Martha Turner.		14. NAME OF HUSBAND OR WIFE Mrs. R.H. 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. None		17. INFORMANT Address Mrs. R.H. Anderson; White Plains, NY	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Infarction			INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Arteriosclerosis			
DUE TO (c) 420.1			
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 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 Jackson, Tenn.	COUNTY _____ STATE _____
21. I attended the deceased from 9/20/57 to 9/3/59 and last saw him alive on 9/2/59 Death occurred at 12 noon on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE H. C. Berteloff M.D. (Degree or title)	22b. ADDRESS 634 No Grand	22c. DATE SIGNED 7/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9/4/1959	23c. NAME OF CEMETERY OR CREMATORY Jackson, Tenn.

24. FUNERAL DIRECTOR C.R. Lupton & Sons. 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. SEP 4 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4011

P. O. Address St Louis, Mo

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.