

**MURI DIVISION - OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035776**

**FILED VS. OCT 19 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000 Registrar's No. 1067

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>517 South Warren</b>		d. STREET ADDRESS (If outside, give location) <b>517 South Warren</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>E.</b> Last <b>Anderson</b>			4. DATE OF DEATH Month <b>October</b> , Day <b>8</b> , Year <b>1959</b>			
5. SEX <b>Male</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>9/7/86</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>		11. BIRTHPLACE (City, and state or country) <b>Missouri Christian County</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>George W. Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary E. Hancock</b>		14. NAME OF HUSBAND OR WIFE <b>Phena (Lang) Deceased</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>500-01-1360</b>	17. INFORMANT <b>Mrs. Flossie Scroggins,</b> 814 S. Missouri.
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		<b>Basilar artery thrombosis recurrent</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mts.</b>
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 checked="" 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 _____ 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>31 July 1959</b> to <b>8 Oct 1959</b> and last saw him alive on <b>19 Sept 1959</b> Death occurred at <b>2:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE <b>Francis M. Mark</b> (Describe or title) <b>MD</b>		22b. ADDRESS <b>Springfield, Mo</b>		22c. DATE SIGNED <b>14 Oct 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Meadows Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Taney County, Missouri</b>	

24. FUNERAL DIRECTOR <b>Ralph Thieme Funeral Service</b>	25. DATE RECD. BY LOCAL REG. <b>10-15-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 21 1959

**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

*Harold F. Tuttle*

Licensed Embalmer No. 5079

P. O. Address Springfield

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.