

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

**59-037378**

**FILED VS NOV 12 1959**

**210072**

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTE <b>Rorer Phillips Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2712 a Delmar Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>Anderson</b> Last				4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6/30/1908</b>	9. AGE (last birthday) <b>51</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>house work</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Dennis Langford</b>			13b. MOTHER'S MAIDEN NAME <b>Manlenda</b>			14. NAME OF HUSBAND OR WIFE <b>Willis Anderson</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.		17. INFORMANT Address <b>Willis Anderson-2712a Delmar</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>Acute Posterior Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							<b>420.1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>						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 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>April 14, 1955</b> to <b>Oct. 29, 1959</b> and last saw <sup>her</sup> <del>him</del> alive on <b>Oct. 29, 1959</b> Death occurred at <b>2:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Chas. P. Fard, M.D.</b> (Do, free or title)				22b. ADDRESS <b>2801 N. Taylor</b>		22c. DATE SIGNED <b>11-2-59</b>		
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE <b>11/5/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
24. FUNERAL DIRECTOR <b>Peoples Und.Co. 3100 Franklin Ave.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>NOV 3 1959</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 W. Claude Gardner

Licensed Embalmer No. 34 89

P. O. Address 4500 New

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.