

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 14 1960

-60-005101

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 134

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MACON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in 1b <u>1 DAY</u>		c. CITY OR TOWN <u>MACON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>209 Mc Kay</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>ANDERSON, A</u>				4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-60</u>	9. AGE (last birthday) <u>New Born</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>4</u>		IF UNDER 24 HR Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>MACON, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Herbert Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs. Carolyn Anderson</u>		14. NAME OF HUSBAND OR WIFE			
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. <u>None</u>		17. INFORMANT <u>Hospital Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> DUE TO (b) <u>PREMATURITY</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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		COUNTY	STATE	
21. I attended the deceased from <u>3-4-60</u> to <u>3-5-60</u> and last saw her/him alive on <u>3-5-60</u> Death occurred at <u>3:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Elmer H. Van Dyke, M.D.</u>				22b. ADDRESS <u>Univ. of Mo. Med. Center</u>		22c. DATE SIGNED <u>3/5/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>March 7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laclede</u>		23d. LOCATION (City, town, or county) (State) <u>Laclede Mo</u>			
24. FUNERAL DIRECTOR <u>Brothers Funeral Home</u>		ADDRESS <u>Laclede</u>		25. DATE RECD. BY LOCAL REG. <u>March 6 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Blake Bladder

Licensed Embalmer No. 5019

P. O. Address \_\_\_\_\_

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.