MO DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-005102
STATE FILE NUMBER

FILED VS MAR 14 196038
Registration District No. _____ Primary Registration District No. 3206 Registrar's No. 137

1. PLACE OF DEATH
a. COUNTY Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia
Length of stay in 1b: 15HRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION University of Mo. Medical Center
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY MACON
c. CITY OR TOWN MACON
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 209 McKAY
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Baby Middle: Boy Last: ANDERSON

4. DATE OF DEATH: Month 3 Day 5 Year 60

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 3-4-60

9. AGE (last birthday): N.B.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours 22 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): MACON, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Herbert ANDERSON

13b. MOTHER'S MAIDEN NAME: CAROLYN McClaskey

14. NAME OF ~~HUSBAND OR WIFE~~: 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.: None

17. INFORMANT Address: University of Mo. Medical Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANOXIA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c): _____
INTERVAL BETWEEN ONSET AND DEATH: ½ day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): No

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 3/4/60, to 3/5/60 and last saw her/him alive on 3/5/60
Death occurred at 4:30 Am/pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Raymond Westfield MD

22b. ADDRESS: Univ. of Mo. Med Center, Columbia

22c. DATE SIGNED: 3/5/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3/7/60

23c. NAME OF CEMETERY ~~OR CREMATORY~~: Laclede

23d. LOCATION (City, town, or county) (State): Laclede, Mo.

24. FUNERAL DIRECTOR ADDRESS: Bathews-Hanne Laclede, Mo.

25. DATE RECD. BY LOCAL REG.: March 7 1960

26. REGISTRAR'S SIGNATURE: Mrs. R.E. Palmer

BY AFFIDAVIT OF DOCUMENT

(Licensed Embalmer's Statement on Reverse Side)

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 Gledden

Licensed Embalmer No. 5019

P. O. Address Laredo T

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