

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031536

FILED VS AUG 30 1960

Registration District No. 274 Primary Registration District No. 305V Registrar's No. 296 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Sedalia</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in lb <u>50 years</u>		c. CITY OR TOWN <u>Sedalia</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>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>720 South New York</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRISON</u> Middle <u>Z.</u> Last <u>ANDERSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/88</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carman retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Shops</u>		11. BIRTHPLACE (City and state or country) <u>Bates County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Cathy</u>		14. NAME OF HUSBAND OR WIFE <u>Myrtle Dixon Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>722-07-2130</u>		17. INFORMANT <u>James H. Anderson, 2114 East 9th Sedalia, Mo</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>Acute Congestive Heart Failure.</u> <u>Dissecting Aortic aneurysm</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u>						
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>August 17 1960</u> to <u>August 25 1960</u> and last saw him alive on <u>August 25 1960</u> Death occurred at <u>8:15 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>PV Siegel MD</u> (Degree or title)		22b. ADDRESS <u>Sunkhau, Mo</u>		22c. DATE SIGNED <u>8/27/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>			
24. FUNERAL DIRECTOR <u>James Ewing</u>		ADDRESS <u>Sedalia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/27/1960</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 31 1960

**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 P. E. Baker

Licensed Embalmer No. 2419

P. O. Address Sedalia 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.