

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4943 Terry	

3. NAME OF DECEASED (Type or print) First Marie Middle Lindsley Last Anderson			4. DATE OF DEATH Month 10 Day 13 Year 60			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/23/07	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months 9 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		
12. CITIZEN OF WHAT COUNTRY USA.		13a. FATHER'S NAME ? Anderson		13b. MOTHER'S MAIDEN NAME Vora Moore		
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) no		16. SOCIAL SECURITY NO.		
17. INFORMANT Leona Jeffries 4943 Terry		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		

IMMEDIATE CAUSE (a) Septicemia, Secondary to		INTERVAL BETWEEN ONSET AND DEATH Undet.
DUE TO (b) Urinary Tract Infection, Secondary to		Undet.
DUE TO (c) Cardiovascular Disease (Cerebral Thrombosis)		Undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1		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	
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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.) 422.1
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20c. TIME OF INJURY Hour 11 a.m. Month, Day, Year 10-13-60	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 St. Louis Co. Mo.	COUNTY	STATE
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21. I attended the deceased from 9-27-60 to 10-13-60 and last saw her alive on 10-13-60 Death occurred at 5:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE R. Phillips Jr. MD (Degree or title)	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 10-14-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/18/60	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Wright Funeral Home	ADDRESS 3100 Easton Ave.	25. DATE RECD. BY LOCAL REG. OCT 15 1960	26. REGISTRAR'S SIGNATURE Leona Smith, M.D.
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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 Arthur L. Heileid

Licensed Embalmer No. 4221

P. O. Address 3100 Costa

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.