

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

**=61-016313**

STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 151

**FILED JUN 12 1961**

1. PLACE OF DEATH a. COUNTY <b>Adair</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>38 years</b>		c. CITY OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>112 E. Buchanan</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>112 E. Buchanan</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margurette May Anderson</b>			4. DATE OF DEATH Month Day Year <b>June, 5, 1961</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</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>3/22/1886</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>13</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>		11. BIRTHPLACE (City and state or country) <b>Nevada, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John Miller</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>James 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. <b>none</b>		17. INFORMANT Address <b>James Anderson, Kirksville, Mo.</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>Cerebral Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b>						<b>3 yrs</b>	
DUE TO (c) <b>nephritis</b>						<b>5 yrs</b>	
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"/> N. <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 _____ s.m. _____ p.m. _____	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>June 5-61</b> to <b>June 5-61</b> and last saw her/him alive on <b>June 5-61</b> Death occurred at <b>2:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert C. Jackson MD</b>			22b. ADDRESS <b>Kirksville Mo</b>		22c. DATE SIGNED <b>6-6-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>June 8, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park</b>		23d. LOCATION (City, town, or county) <b>Kirksville, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Dee Riley Funeral Home, Inc., Kirksville, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-6-1961</b>		26. REGISTRAR'S SIGNATURE <b>Dore W. Rathoff</b>		

*W.R. Jackson - Pres.*

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

P.O. STICKLER, M.D.

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

*Kenneth E Hayes*

Licensed Embalmer No. 4890

P. O. Address Kirkville, 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.