

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032068

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 222

AMENDED

FILED SEP 25 1961

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Callaway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Audra</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> | | Length of stay in 1b <u>1 1/2 yrs</u> | c. CITY OR TOWN <u>Mexico</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fulton St Hosp</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>605 E JACKSON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>Lee</u> Last <u>ANDERSON</u> | | | 4. DATE OF DEATH Month <u>9</u> - Day <u>17</u> - Year <u>61</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</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>3-13-1908</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u> | 9. AGE (last birthday) <u>53</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u> |
| 11. BIRTHPLACE (City and state or country) <u>Stoughtonville MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S</u> | |
| 13a. FATHER'S NAME <u>JAMES T Anderson</u> | | 13b. MOTHER'S MAIDEN NAME <u>Nelle Dooley</u> | 14. NAME OF HUSBAND OR WIFE <u>None</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> | | | 17. INFORMANT <u>Mrs Cecil Boloney hoaristown MO</u> 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) <u>Strangulation</u> DUE TO (b) <u>By Hanging</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u> |
| 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 checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u> |
| 20f. CITY, TOWN, OR LOCATION <u> </u> | | COUNTY <u> </u> | STATE <u> </u> |
| 21. I attended the deceased from <u>9/17/61</u> to <u>9/17/61</u> and last saw her/him alive on <u>X X Xxy</u> Death occurred at <u>9:45 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>William V Towreell MD</u> | | 22b. ADDRESS <u>Fulton St Hosp</u> | 22c. DATE SIGNED <u>9/17/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Sept-19-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Stoughtonville Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Stoughtonville MO</u> |
| 24. FUNERAL DIRECTOR <u>E. H. Agnew Paris, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Sept-18-1961</u> | 26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

SEP 26 1967

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 *E. H. Agnew*

Licensed Embalmer No. 4000

P. O. Address Paris, 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.