

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-002621

STATE FILE NUMBER

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 16

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe,</u>		c. CITY OR TOWN <u>Chillicothe</u>	
Length of stay in 1b: <u>71 Yrs.</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>420 Herriman St.</u>		d. STREET ADDRESS (If outside, give location) <u>420 Herriman St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERT LAWRENCE ANDERSON</u>			4. DATE OF DEATH Month Day Year <u>JANUARY 24, 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</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>8/2/1890</u>
9. AGE (last birthday) <u>71</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. POST OFFICE</u>	11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</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>IMOGENE JONES</u>		14. NAME OF HUSBAND OR WIFE <u>KATHERINE BERRY</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>NONE</u>	
17. INFORMANT <u>MRS. KATHERINE ANDERSON</u>		Address <u>Chillicothe, 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>Carcinoma of prostate</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1) Diabetes mellitus 2) Uremia</u>			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 Month, Day, Year a.m. p.m.			
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>July 1953</u> to <u>Jan. 24 1962</u> and last saw him alive on <u>Jan 23, 1962</u> Death occurred at <u>3:00</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William L. Fair, M.D.</u> (Degree or title)		22b. ADDRESS <u>Chillicothe, Mo.</u>	22c. DATE SIGNED <u>1/26/62</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1/28/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>South Cemetery</u>	23d. LOCATION (City, town, or county) <u>Livingston Co. Mo.</u> (State)
24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME: Chillicothe, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Jan. 26, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTAED OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

MAR 13 1962

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

John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address Chillicothe, Miss

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.