

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005920

STATE FILE NUMBER

AMENDED

FILED MAR 6 1962 Primary Registration District No. 5295 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Perrin</u>		Length of stay in 1b	c. CITY OR TOWN <u>Perrin</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Perrin</u>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>See</u> Last <u>Anderson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1962</u>					
5. SEX <u>female</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>6/5/1886</u>	9. AGE (last birthday) <u>75</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 life, even if retired) <u>Homeowner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Gower Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Harris</u>			13b. MOTHER'S MAIDEN NAME <u>Ida Yates</u>		14. NAME OF HUSBAND OR WIFE <u>Calvin 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>none</u>		17. INFORMANT <u>Calvin Anderson</u>		Address <u>Perrin, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			<u>30 mins</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>atherosclerosis, cerebral</u>		
			DUE TO (c) <u>5+ yrs.</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		

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>1957</u> to <u>Mar 1, 1962</u> and last saw her <u>alive on Jan 31, 1962</u> Death occurred at <u>2 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Dr Luckenill MD</u>		22b. ADDRESS <u>Plattsburg, Mo.</u>		22c. DATE SIGNED <u>3-1-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u># 3/3/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Int. Zion</u>		23d. LOCATION (City, town, or county) (State) <u>Clinton County Mo.</u>

24. FUNERAL DIRECTOR <u>Syon Funeral Home Inc. Plattsburg Mo.</u>	ADDRESS <u>3-3-1962</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Mary W Seearse</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.