

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009859

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 189

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 2 1962

VS 300	DATE AMENDED
Rev. 4/59	
10109	
20870	
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4 1	
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9492X	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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122-0	INSTEAD OF
13 3-0	

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>RAILS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b	c. CITY OR TOWN <u>Center</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>UNIVERSITY OF MO. MEDICAL CENTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 2.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maude Adeline Anderson</u>			4. DATE OF DEATH Month Day Year <u>3-28-62</u>
5. SEX <u>FEMALE.</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-30</u>
9. AGE (last birthday) <u>31</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Center, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Danny A. Anderson</u>	
13b. MOTHER'S MAIDEN NAME <u>Darlene LEEK</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT Address <u>Medical Record U.M.M.C.</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>Respiratory Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bilateral Hydrothorax</u>			<u>UNKNOWN</u>
DUE TO (c) <u>pneumonitis</u>			<u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Marked exogenous obesity</u>			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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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>March 28, 1962</u> to <u>March 28, 1962</u> and last saw her/him <u>alive or dead when first seen</u> Death occurred at <u>7:00</u> <u>A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Carl C. Pearson, M.D.</u>		22b. ADDRESS <u>Columbia, Missouri</u>	22c. DATE SIGNED <u>3/28/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Mar 28-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cem.</u>	23d. LOCATION (City, town, or county) <u>Center Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Clyde C. Welker Mo</u>		25. DATE RECD. BY LOCAL REG. <u>March 28-62</u>	26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 4 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 Clyde C. Welker

Licensed Embalmer No. 3820

P. O. Address Perry 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.