

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-009913
STATE FILE NUMBER

042 1000 337
Registration District No. Primary Registration District No. Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 26 1962

VS 300
Rev. 4/59

1 5117

2 5117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

CERTIFICATION

BY AFFIDAVIT OF

D. Stullard, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri		c. CITY OR TOWN St. Joseph, Missouri	
Length of stay in 1b Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		d. STREET ADDRESS (If outside, give location) 2103 Commercial Street	
3. NAME OF DECEASED (Type or print) First ARCHIE Middle TALBERT Last ANDERSON		4. DATE OF DEATH Month March Day 15 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1883
9. AGE (last birthday) 78		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) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Buchanan County, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James Scott Anderson	
13b. MOTHER'S MAIDEN NAME Margaret Deppin		14. NAME OF HUSBAND OR WIFE Ella Anderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Son		Address Mr. Lee W. Anderson - St. Joseph, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation			INTERVAL BETWEEN ONSET AND DEATH seconds
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart failure			years
DUE TO (c) Calcific aortic stenosis			years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy			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 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 _____ a.m. _____ p.m.	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 1958 to 3/15/62 and last saw him alive on 3/15/62 Death occurred at 8:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Ronald Stallard, M.D. (Degree or title)		22b. ADDRESS 902 E. Grand	22c. DATE SIGNED 3/22/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 19, 1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Missouri (State)
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Mar. 23 1962	26. REGISTRAR'S SIGNATURE Mrs. Clark Woodell

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 Raymond H Troor

Licensed Embalmer No. 5147

P. O. Address St Joseph 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.