

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-011704

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 65

FILED MAR 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Vienna</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stott Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt #1 - Vienna</u>
3. NAME OF DECEASED (Type or print) First <u>Tobie</u> Middle <u>EVERETT</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>16</u> - Year <u>62</u>	
5. SEX <u>Male</u>	6. COLOR, OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-81</u>
9. AGE (last birthday) <u>80</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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Wright, Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>ANDREW J. ANDERSON</u>	
13b. MOTHER'S MAIDEN NAME <u>LUCY MURRELL</u>		14. NAME OF HUSBAND OR WIFE <u>MILLIE C. MURRELL</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>no</u>	
17. INFORMANT <u>MILLIE ANDERSON-VIENNA, 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>Arterio sclerotic Heart Disease with coronary Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u>			
DUE TO (c)			
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 _____ 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 <u>3/3/62</u> to <u>3/16/62</u> and last saw ^{her} him alive on <u>3/12/62</u>		Death occurred at <u>9 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Dr. Fisher M.D.</u> (Degree or title)		22b. ADDRESS <u>Lebanon, Mo</u>	22c. DATE SIGNED <u>3/17/62</u> (State)
23a. BURIAL CREMATION, REMOVED, OR OTHER	23b. DATE <u>3-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Colley Cemetery</u>	23d. LOCATION (City, town, or county) <u>Waynesville Mo.</u>
24. FUNERAL DIRECTOR <u>W. Cunningham</u> Address <u>Vienna Mo.</u>		25. DATE REC'D. BY LOCAL REG. <u>3-17-1962</u>	26. REGISTRAR'S SIGNATURE <u>Abella L. Day</u>

USE BLACK INK, OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

James Douglas Griswold
5099

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 *James Douglas Griswold*

Licensed Embalmer No. 5099

P. O. Address Rebannon, 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.

Permit issued 3-17-1962 A.D.L.