

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018040

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 568

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

15117
23308

3

4 1

5 0

6

7 2

8 2

94500

10

11

1293-0

13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF *H. Tahir, M.D.* MEDICAL CERTIFICATION

FILED MAY 28 1962

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN Kansas City	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph State Hospital		d. STREET ADDRESS (If outside, give location) 1665 Holly St.	
3. NAME OF DECEASED (Type or print) First Clara Middle Anderson Last Anderson		4. DATE OF DEATH Month May Day 18 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (last birthday) 86		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) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sweden
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE	
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. none	
17. INFORMANT State Hosp. Records, St. Joseph, Mo.		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) Congestive Heart failure DUE TO (b) Bronchopneumonia DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.)		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	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 St. Joseph, Mo.	
20g. COUNTY		20h. STATE	
21. I attended the deceased from _____ to 5-18-62 and last saw her/him alive on 5-18-62 . Death occurred at 1:30 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Mohammed Tahir M.D.</i>		22b. ADDRESS State Hospital, St. Joseph, Mo.	
22c. DATE SIGNED 5-18-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE May 18, 1962	
23c. NAME OF CEMETERY OR CREMATORY Kansas City Missouri		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <i>Walter Bowman</i>		25. DATE RECD. BY LOCAL REG. May 18, 1962	
ADDRESS St. Joseph, Mo.		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Standell</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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 William Spelling

Licensed Embalmer No. 4535

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.