

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029996

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38

38

Primary Registration District No. 3006

Registrar's No. 500

FILED SEP 10 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD BE READY

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Univ. Mo. Med Center</u> Length of stay in lb <u>6 days</u>		c. CITY OR TOWN <u>Palmyra</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Columbia, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH-FREDD-ANDERSON</u>			4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-92</u>
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Coatsburg Ill.</u>
13a. FATHER'S NAME <u>Carl E. Eger</u>		13b. MOTHER'S MAIDEN NAME <u>Anna S. Jackson</u>	14. NAME OF HUSBAND OR WIFE <u>Chas E. Anderson</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Hospital Records UMMC</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>Cessation of Heart</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u>			<u>1-2 days</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>			<u>2 years</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 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>Aug 28 '62</u> to <u>Sept 3 '62</u> and last saw her/him alive on <u>Sept 3 '62</u> . Death occurred at <u>6:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John M. Landrum MD</u> (Degree or title)		22b. ADDRESS <u>M.U. Medical Center</u>	22c. DATE SIGNED <u>9-4-62</u>
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE <u>9/4/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Providence Philadelphia, Mo.</u>
24. FUNERAL DIRECTOR <u>Wiebey Funeral Home</u> ADDRESS <u>Paris, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 4 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>

7907 07 1962

EMBALMENT CERTIFICATE

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. Wiley

Licensed Embalmer No. 3820

P. O. Address Peru, 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.

EMBALMENT CERTIFICATE