

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002947

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 291 Primary Registration District No. _____ Registrar's No. 2

STATE FILE NUMBER

FILED JAN 16 1963

1. PLACE OF DEATH a. COUNTY <u>PUTNAM</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PUTNAM</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>UNIONVILLE</u>		c. CITY OR TOWN <u>UNIONVILLE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10 St</u>		d. STREET ADDRESS (If outside, give location) <u>10 St</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS FRANKLIN ANDERS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>63</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Putnam Co MO</u>	
13a. FATHER'S NAME <u>JOHN ANDERS</u>		13b. MOTHER'S MAIDEN NAME <u>HARRIETT ROBINSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>u</u> (If yes, give war or dates of service)		17. INFORMANT <u>TEMPA ANDERS-UNIONVILLE, MO</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>Chronic glomerular nephritis</u> DUE TO (b) <u>Chronic prostatitis</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) <u>Regenerative Myocarditis</u>		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 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 _____		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
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.)	
21. I attended the deceased from <u>7-10-55</u> to <u>1-10-63</u> and last saw him alive on <u>1-10-63</u> Death occurred at <u>7:10 P</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>J.W. McDonald Do</u> ADDRESS <u>Unionville MO</u> 22c. DATE SIGNED <u>1-12-63</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>1-13-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>THOMPSON CEM</u>	23d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MO</u>
24. FUNERAL DIRECTOR <u>FD. Husted & Son - Unionville MO</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>1-13-63</u> 26. REGISTRAR'S SIGNATURE <u>Marcell Durbin</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

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 Murphy Husted

Licensed Embalmer No. 330

P. O. Address Monroe, 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.