

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007490

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 38

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clark Township</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 miles south of Moscow Mills</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lincoln</u> c. CITY OR TOWN <u>Clark Township</u> d. STREET ADDRESS (If outside, give location) <u>2 miles south of Moscow Mills</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Casper Owen Anderson</u>			4. DATE OF DEATH Month Day Year <u>March 6 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</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>11-5-1901</u>
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>Moscow Mills, Mo.</u>
13a. FATHER'S NAME <u>Casper Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Belle Owen</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Anderson</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>None</u>	17. INFORMANT Address <u>Helen Anderson Moscow Mills, 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>pulmonary embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic chr pulmonary</u> DUE TO (c) <u>bronchial + cardiac asthma</u>			INTERVAL BETWEEN ONSET AND DEATH.
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>July 1962</u> to <u>March 6, 1963</u> and last saw him alive on <u>March 4, 1963</u> Death occurred at <u>one o'clock</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Addison Tombs, M.D.</u>		22b. ADDRESS <u>Troy, Mo.</u>	22c. DATE SIGNED <u>3-6-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-9-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Troy City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Troy, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Kemper-Marsh Fun. Home, Troy, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-7-1963</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte Beck</u>

APR 9 1963

STATE OF MISSOURI

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 *[Handwritten Signature]*

Licensed Embalmer No. 4012

P. O. Address *[Handwritten Address]*

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.