

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008261

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1288**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 19 1963

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 ---		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey COUNTY Mercer	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 26 days	c. CITY OR TOWN Trenton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6615 Lindenwood Place		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 632 Greenwood
3. NAME OF DECEASED (Type or, print) First Lucy Middle Amelia Last Anderson		4. DATE OF DEATH Month February Day 6 Year 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-25-82
9. AGE (last birthday) 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Hartford, Pennsylvania
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Aaron Savige	
14. MOTHER'S MAIDEN NAME Amelia Hartzell		15. NAME OF HUSBAND OR WIFE George R. Anderson (Dec.)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Address Mrs. Mildred Blattner 6615 Lindenwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 4 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 491x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Gen. Arteriosclerosis			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 checked="" 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 1-16-63 to 2-6-63 and last saw her/him alive on 2-5-63 Death occurred at 4:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Raymond O. Frederick, M.D.		22b. ADDRESS 3720 Washington	22c. DATE SIGNED 2-7-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Rail	23b. DATE 2-7-63	23c. NAME OF CEMETERY OR CREMATORY Ewing Cemetery	23d. LOCATION (City, town, or county) (State) Ewing, Pennsylvania
24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY		ADDRESS SAM	25. DATE RECD. BY LOCAL REG. 2-6-1963
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

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Dr. Raymond O. Frederick
3720 Washington
JE. 3-6111

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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 John S. Denny

Licensed Embalmer No. 4194

P. O. Address St. Louis, 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.