

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009167

STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 75

1. PLACE OF DEATH a. COUNTY <i>Henry</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Henry</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Clinton</i>		c. CITY OR TOWN <i>Clinton</i> 0423 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Home</i>		d. STREET ADDRESS (If outside, give location) <i>506 N Washington</i>	
Length of stay in lb <i>4 years</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Susie</i> Middle <i>Leonard</i> Last <i>Anderson</i>			4. DATE OF DEATH Month <i>Mar</i> Day <i>30</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/29/1857</i>	9. AGE (In years last birthday) <i>102</i>	IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Henry Co Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13a. FATHER'S NAME <i>Isaac Leonard</i>			13b. MOTHER'S MAIDEN NAME <i>Harriet</i>		14. NAME OF HUSBAND OR WIFE <i>Will Anderson</i>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs Henry Reed</i>		Address <i>Clinton Mo</i>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medullary Paralysis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Hrs</i>
DUE TO (b) <i>Cerebral Anoxia</i>			
DUE TO (c) <i>Generalized Atherosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Senility - Incontinence -</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>

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 Month, Day, Year o.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 *3-30-59* to *3-30-59* and last saw her ^{him} alive on *3-30-59*
Death occurred at *8:45 AM* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Arturo Gonzales</i> (Degree or title)		22b. ADDRESS <i>2 717 E Jefferson Clinton</i>		22c. DATE SIGNED <i>4-1-59</i>	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/2/59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Antioch Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Clinton Mo</i>	
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24. FUNERAL DIRECTOR <i>Consuelo Clinton Mo</i>		25. DATE RECD. BY LOCAL REG. <i>4-1-59</i>		26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

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 *J. E. Connelley*

Licensed Embalmer No. *189 F*

P. O. Address *Cheriton*

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.