URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-034613

STATE FILE NUMBER

FILED VS OCT 10 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4826

NDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lees Summit
Length of stay in 1b 2 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hosp
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Lees Summit
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 408 So. Market
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: WILSON EUGENE ANDERS

4. DATE OF DEATH Month Day Year: Sept. 24 1960

5. SEX: MALE

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 6-21-1907

9. AGE (last birthday): 53

IF UNDER 1 YEAR Months Days: —

IF UNDER 24 HR Hours Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): Calhoun Mo

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Wm. Z. ANDERS

13b. MOTHER'S MAIDEN NAME: LILY ONWILER

14. NAME OF HUSBAND OR WIFE: DOROTHY LEE ANDERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 490-05-8607 UNKNOWN

17. INFORMANT: Dorothy Lee Anders Address Lees Summit Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Medullary Paralysis — INTERVAL BETWEEN ONSET AND DEATH: 1 MIN

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Thrombosis. — @ 1 month

DUE TO (c): Generalized Arteriosclerosis — @ 5 years.

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 6-1-60 to 9-24-60 and last saw her/him alive on 9-24-60

Death occurred at 6:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William J. Rhode DO.

22b. ADDRESS: 320 S. Douglas Lees Summit

22c. DATE SIGNED: 9-24-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: Sept. 25, 1960

23c. NAME OF CEMETERY OR CREMATORY: Calhoun Cemetery

23d. LOCATION (City, town, or county) (State): Calhoun, Mo.

24. FUNERAL DIRECTOR: Vansant Funeral Home

ADDRESS: Clinton Mo

25. DATE RECD. BY LOCAL REG.: 9-24-60

26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF William J. Rhode MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. T. L. Vaucant

Licensed Embalmer No. 3779

P. O. Address Clinton,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.