

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-001415

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 68

FILED JAN 21 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2 3168

3

4 2

5 9

6

7 0

8 1

9 X

10

11 123

12 92-3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF M. Tillman

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City,</b>		Length of stay in 1b <b>5 yrs.</b>	c. CITY OR TOWN <b>Kansas City,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. General Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1000 Paseo Blvd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Clarence H. Anderson</b>			4. DATE OF DEATH Month <b>January</b> Day <b>3,</b> Year <b>1963</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-21-15</b>
9. AGE (last birthday) <b>47</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>	11. BIRTHPLACE (City and state or country) <b>Windsor, Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baptist</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>E. T. Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Beulah Brooks</b>	
14. NAME OF HUSBAND OR WIFE <b>unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>488 28 2483</b>		17. INFORMANT <b>Edgar Anderson, K. C., Mo.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Fracture of chest base</b> DUE TO (c) <b>Auto-Fatality</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Auto Accident</b>	
20c. TIME OF INJURY Hour <b>9:25</b> P.M. Month, Day, Year <b>Jan. 3, 1963</b>			
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.) <b>19th &amp; Tracy</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Jackson, Mo.</b> COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>M. Tillman M.D. Deput Coroner</b> (Degree or title)		22b. ADDRESS <b>1618 Lydia Ave.</b>	22c. DATE SIGNED <b>1/4/63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-7-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Oak Cemetery</b>
24. FUNERAL DIRECTOR <b>Mrs. Meek's Mortuary, K. C., Mo.</b> ADDRESS		23d. LOCATION (City, town, or county) <b>Windsor, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>1-7-63</b>
		26. REGISTRAR'S SIGNATURE <b>K. L. Long</b>	

(Licensed Embalmer's Statement on Reverse Side)

**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 Millard B. Perkins

Licensed Embalmer No. 5013

P. O. Address KCMO

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.