

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **12881**

FILED APR 25 1949

BIRTH NO. _____ REG. DIST. NO. **155** PRIMARY REG. DIST. NO. **3127** Registrar's No. **73**

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City, Missouri	
c. LENGTH OF STAY (In this place) 3 Years		d. STREET ADDRESS (If rural, give location) 1127 West Mineral St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jane Chinn Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Russell b. (Middle) M. c. (Last) Anderson			4. DATE OF DEATH (Month) (Day) (Year) April 5 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 10 1915
9. AGE (In years last birthday) 33		10. MONTH 11	11. DAYS 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sparta, Mich
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Richard Anderson		13b. MOTHER'S MAIDEN NAME Florence (not known)	14. NAME OF HUSBAND OR WIFE Opal Anderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Opal Anderson
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory Collapse following abdominal surgery DUE TO (b) for gastric ulcers DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 51	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-22 , 19 49 , to 4-5 , 19 49 , that I last saw the deceased alive on 4-5-49 , 19____, and that death occurred at 10:15 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>[Signature]</i>		23b. ADDRESS Carterville Mo	23c. DATE SIGNED 4-9-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 9, 1944	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.	24d. LOCATION (City, town, or county) (State) Webb City, Mo
DATE REC'D BY LOCAL REG. APR. 11-49	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE Johnston, Prince & Sampson	
		ADDRESS Webb City, Mo.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 25 1949

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, ~~only~~

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Jack C. Simpson*

Licensed Embalmer No. *4647*

P. O. Address *Webb City 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 this body is not embalmed, fact should be so stated above.