

APR 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13222**

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 2026 Registrar's No. 170

445
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1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN INDEPENDENCE		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN INDEPENDENCE		0485	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION INDEPENDENCE SAN-HOSP		d. STREET ADDRESS (If rural, give location) 638 S. PARK	

3. NAME OF DECEASED (Type or Print) a. (First) JACOBINA b. (Middle) ANDERSEN c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) APRIL 19 1952		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		8. DATE OF BIRTH JUNE 14-1861	
11. BIRTHPLACE (City and State or Foreign Country) NORTH-UTRUP-DENMARK		12. CITIZEN OF WHAT COUNTRY? USA		9. AGE (In years last birthday) Months Days 90	

13a. FATHER'S NAME THOMAS JACOBSEN		13b. MOTHER'S MAIDEN NAME MAREN JACOBSEN		14. NAME OF HUSBAND OR WIFE PETER ANDERSEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOWARD P. ANDERSEN INDEP. MO	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Fracture femur			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 120			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) m.		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 Mar 25, 1952 to Apr 19, 1952, that I last saw the deceased alive on April 19, 1952, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Shes. A. Grosske, M.D.		23b. ADDRESS Independence, Mo.		23c. DATE SIGNED 4/21/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE APR. 22-1952		24c. NAME OF CEMETERY OR CREMATORY MAUND GROVE	
24d. LOCATION (City, town, or county) (State) INDEPENDENCE MO.		25. FUNERAL DIRECTOR'S SIGNATURE Henry W. Stahl		ADDRESS INDEP. MO.	
DATE REC'D BY LOCAL REG. 4-22-52		REGISTRAR'S SIGNATURE [Signature]		354	

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

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

Student Embalmer

Signed

Henry W. Stahl

Licensed Embalmer No. *3181*

P. O. Address *Independence*

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.