

FILED FEB 11 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14696**
Registrar's No. **12062**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2259	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 25 5 N. 9th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) RALPH b. (Middle) c. (Last) ANDERSON		4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 29, 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug. 25, 1891
9. AGE (In years last birthday) 61		10. MONTHS 61	11. DAYS 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Kirkland, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Peter Anderson		13b. MOTHER'S MAIDEN NAME Christine Anderson	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Lou Anderson, Rockford, Ill.
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) PULMONARY TUBERCULOSIS, EARLY ADVANCED - 10 yrs. INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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		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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X	
22. I hereby certify that I attended the deceased from 12-22-52 , 19____, to 12-29-52 , 19____, that I last saw the deceased alive on 12-29-52 , 19____, and that death occurred at 2:10 P. m., from the causes and on the date stated above.			
23a. SIGNATURE H. A. Grodzki		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 12-29-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-30-52	24c. NAME OF CEMETERY OR CREMATORY Kirkland, Ill.	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. DEC 30 1952	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	

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

John J. Haines
.....
Licensed Embalmer No. *8198*
P. O. Address *A. J. Haines*

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.