

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5699**
156

FILED FEB 18 1953

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

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 KANSAS CITY	c. LENGTH OF STAY (in this place) 5 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION MEMORAH MEDICAL CENTER		d. STREET ADDRESS (If rural, give location) 3820 BASE 0 3538	

3. NAME OF DECEASED (Type or Print) a. (First) LEOTA b. (Middle) _____ c. (Last) ANDERSON	4. DATE OF DEATH (Month) (Day) (Year) 1 23 53
--	--

5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2 SEPT 18 1868	9. AGE (In years last birthday) Months Days 84 53
----------------------	-------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME Housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) SULLIVAN COUNTY, INDIANA	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	---

13a. FATHER'S NAME Alexander O'Dell	13b. MOTHER'S MAIDEN NAME MALINDA HIGDON	14. NAME OF HUSBAND OR WIFE FRAS. ANDERSON
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mrs. Josephine Waddell	ADDRESS 3820 Base 0 Kansas City, 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		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC FAILURE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart disease DUE TO (c) Generalized Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. AUTOPSY			4200

19a. DATE OF OPERATION 1-23-53	19b. MAJOR FINDINGS OF OPERATION/AUTOPSY Broncho pneumonia - Arteriosclerosis	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____	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 **Jan 20, 1953**, to **Jan 23, 1953**, that I last saw the deceased alive on **Jan 23, 1953**, and that death occurred at **10:32 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE David Waxman MD (Degree or title)	23b. ADDRESS M.O.O 46802 Prospect	23c. DATE SIGNED 1-23-53
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE JAN 24 1953	24c. NAME OF CEMETERY OR CREMATORY LITTLE ROCK CEMETERY	24d. LOCATION (City, town, or county) (State) SHELburn, INDIANA
--	------------------------------	--	--

DATE REC'D BY LOCAL REG. 1-24-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE DW Newcomer ADDRESS 1331 Pine Street Kansas City, Mo
---	--	---

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

Charles H. Stickney

Licensed Embalmer No. *4560*

P. O. Address *11th St. 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.