

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32826

State File No.

FILED OCT 15 1953

9255

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ | | | | | |
| b. CITY OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) _____ | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | | | e. STREET ADDRESS (If rural, give location) 21 2802 Delmar | | | | | |
| 3. NAME OF DECEASED (Type or Print) Katie Anderson | | | a. (First) _____ b. (Middle) _____ c. (Last) _____ | | | 4. DATE OF DEATH (Month) (Day) (Year) 9 20 53 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE Colored | | 7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) MARRIED | | 8. DATE OF BIRTH MAY 8 1896 | | | |
| 9. AGE (In years last birthday) 57 | | IF UNDER 1 YEAR Months 4 Days 12 | | IF UNDER 1 HRS. Hours _____ Min. _____ | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | | 11. BIRTHPLACE (City and State or Foreign Country) PORT GIBSON MISS | | | |
| 12. CITIZEN OF WHAT COUNTRY? _____ | | | 13a. FATHER'S NAME HENRY DOTSON | | 13b. MOTHER'S MAIDEN NAME ANGELINE FRAZLER | | 14. NAME OF HUSBAND OR WIFE VERNON ANDERSON | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME Vernon Anderson ADDRESS 2802 Delmar | | | | |
| 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) Cerebral Thrombosis 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. Hypertensive Heart Disease G. I. Malignancy | | | | INTERVAL BETWEEN ONSET AND DEATH Undt. | |
| 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) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 332XH | | | | | |
| 22. I hereby certify that I attended the deceased from 9-3 , 19 53 , to 9-20 , 19 53 , that I last saw the deceased alive on 9-20 , 19 53 , and that death occurred at 10:05P m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) E. B. Williams, M. D. | | | | 23b. ADDRESS 2601 N. Whittier | | 23c. DATE SIGNED 9-21-53 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 24b. DATE 9-26-53 | | 24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PK. cem | | 24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO | | | |
| DATE REC'D BY LOCAL REG. SEP 25 1953 | | REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.F. WALTON 2707 STODDARD ST | | | | | |

E.P. (Licensed Embalmer's Statement on Reverse Side)

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

L. 5612
J. 8494
C. 0786

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 *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *4524 Al*

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.