

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2542

State File No. ....

FILED FEB 2 1954

0630

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>45 yrs.</b>		e. STREET ADDRESS (If rural, give location) <b>4476 Enright</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		<b>2199</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Cain</b>	b. (Middle)	c. (Last) <b>Anderson</b>	4. DATE OF DEATH (Month) (Day) (Year)
				<b>1 19 54</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>March 4, 1884</b>	9. AGE (In years last birthday) <b>69</b>	# UNDER 1 YEAR Months <b>10</b>	# UNDER 1 WEEK Days <b>15</b>	# UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wagoner Electric</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Wythville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	

13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Fannie S. Anderson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>493-03-7238</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Fannie S. Anderson</b>	ADDRESS <b>4476 Enright</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Cardiovascular Disease with Mild Failure</b>		
	ANTECEDENT CAUSES Morbidity 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. <b>Cerebral Hemorrhage</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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? <b>443X</b>

22. I hereby certify that I attended the deceased from 1-13, 1954, to 1-19, 1954, that I last saw the deceased alive on 1-19, 1954, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>E. B. Williams</b>	23b. ADDRESS <b>M.D. 2601 N. Whittier</b>	23c. DATE SIGNED <b>1-19-54</b>
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24a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1/22/54</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Louisville, Kentucky</b>
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DATE REC'D BY LOCAL REG. <b>JAN 20 1954</b>	REGISTRAR'S SIGNATURE <b>Charles J. Gates</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Gates</b>	ADDRESS <b>4107 Finney Ave.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Arthur L. Hillier*

Licensed Embalmer No. *429*

P. O. Address *45240*

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.