

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5868**

BIRTH NO. **FILED MAR 8 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1873**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis,		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 St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 3651 Cass.	

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle)	c. (Last) Anderson.	4. DATE OF DEATH (Month) (Day) (Year) February 27, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 7 1893	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofers	10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME John Anderson	13b. MOTHER'S MAIDEN NAME Mary Lang.	14. NAME OF HUSBAND OR WIFE Mary
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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)	16. SOCIAL SECURITY NO. 488-05-4224	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Agnes Hagan 2120 67th St.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis with brain damage.		
	ANTECEDENT CAUSES 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"/>
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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)
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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 4500
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22. I hereby certify that I attended the deceased from **Dec. 4, 1953**, to **February 27, 54**, that I last saw the deceased alive on **Feb. 27, 1954**, and that death occurred at **12:10A.**, from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Palmer Eugene Bowlich M.D.	23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 2-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/1/54	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. MAR 1 1954	REGISTRAR'S SIGNATURE J. Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 N. Euclid Ave.
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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... *Albert Mayfield*

Licensed Embalmer No. *30*

P. O. Address *St. Louis*

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.