

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 503

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>42 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>1918 Dewey Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1918 Dewey Ave.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ora</u> b. (Middle) <u>Chester</u> c. (Last) <u>Anderson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 12 1954</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 15, 1882</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Custodian</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Company</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Marion, Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Jasper Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Pricilla Lowder</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Rosa Anderson</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Rosa Anderson</u>	ADDRESS <u>St. Joseph, Mo.</u>
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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 <u>3 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>under</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		
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 <u>334 X</u>	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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 12-18, 1952 to 5-12, 1954, that I last saw the deceased alive on 4-30, 1954, and that death occurred at 8:15 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Clara P. [Signature]</u>	23b. ADDRESS <u>St. Joseph Mo</u>	23c. DATE SIGNED <u>5-13-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>May 14, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Redding, Iowa Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Redding, Iowa</u>
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DATE REC'D BY LOCAL REG. <u>May 18, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u> 485	25. FUNERAL DIRECTOR'S SIGNATURE <u>Home Funeral Home</u>	ADDRESS <u>St. Joseph Mo</u>
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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..... *Charles E. Bennett* .....

Licensed Embalmer No. *467*

P. O. Address *St. Joseph*

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.