

FILED DEC 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42139**
Registrar's No. **10812**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10812																			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri				b. COUNTY St. Louis																	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) 5 days		c. CITY OR TOWN Jennings		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 Johns Hospital				e. STREET ADDRESS (If rural, give location) 4 Siemens drive																					
3. NAME OF DECEASED (Type or Print)			a. (First) Lillian			b. (Middle) _____			c. (Last) Anderson			4. DATE OF DEATH (Month) (Day) (Year) 11-23-54													
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 9-21-1900		9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 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 at home				11. BIRTHPLACE (City and State or Foreign Country) County Durham, England				12. CITIZEN OF WHAT COUNTRY? USA													
13a. FATHER'S NAME Thomas Cutty				13b. MOTHER'S MAIDEN NAME Sarah Hane				14. NAME OF HUSBAND OR WIFE Todd Theol 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 E. Tattich, Jennings, Mo.				ADDRESS _____													
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma pectus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with generalized metastases DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.												INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION 9-17-54				19b. MAJOR FINDINGS OF OPERATION Carcinoma pectus & metastases								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? 154X																	
22. I hereby certify that I attended the deceased from 9-15 , 19 54 , to 11-23 , 19 54 , that I last saw the deceased alive on Nov 23 , 19 54 , and that death occurred at 9:30 p.m. , from the causes and on the date stated above.																									
23a. SIGNATURE (Degree or title) H. H. Siesener M.D.								23b. ADDRESS 6000 W. Flourissant				23c. DATE SIGNED Nov 25, 54													
24a. BURIAL, CREMATION, REMOVAL (Specify) removal				24b. DATE 11-23-54				24c. NAME OF CEMETERY OR CREMATORY _____				24d. LOCATION (City, town, or county) (State) DuQuoin, Illinois													
DATE REC'D BY LOCAL REG. NOV 27 1954				REGISTRAR'S SIGNATURE Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE Schroeder, DuQuoin, Ill.				ADDRESS _____													

WRITE PLAINLY—USING UNFAADING 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.....

Licensed Embalmer No.....

P. O. Address.....

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.