

FILED MAY 16 1955

STANDARD CERTIFICATE OF DEATH

State File No. 11760  
1701

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1701

1. PLACE OF DEATH  
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE MO  
b. COUNTY Davies

b. CITY (Outside corporate limits, write RURAL and give township) Kansas City  
c. LENGTH OF STAY (in this place) 6 weeks

c. CITY OR TOWN Gallatin  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph Hosp

STREET ADDRESS (If rural, give location) R.R. #1 Gallatin MO

3. NAME OF DECEASED  
a. (First) Olivia b. (Middle) c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year) 4-17-55

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M

8. DATE OF BIRTH 3-9-1863

9. AGE (in years last birthday) 92 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) MO

12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Gustav J. Jellander

13b. MOTHER'S MAIDEN NAME unknown

14. NAME OF HUSBAND OR WIFE John A. 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 ADDRESS Mrs. C. H. Gaines Gallatin, Mo.

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) Fracture, Femur, left.  
ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (c) Broncho pneumonia, enteritis, Cystitis

INTERVAL BETWEEN ONSET AND DEATH 48 days  
E 9030 20

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Broken Hip

20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Gallatin, Davies MO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Mar 1 1955 m.

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? Fall in Bathroom

22. I hereby certify that I attended the deceased from Mar 7, 1955, to April 17, 1955, that I last saw the deceased alive on April 16, 1955, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE Garrett Pipkin M.D. (Degree or title)

23b. ADDRESS 409 Argyle Bldg

23c. DATE SIGNED 4/17/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 4/17/55

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Ottowa Kas. MO

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 4-17-55 neva meishell

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Steve W. Colwell R.C.M.O.

(Licensed Embalmer's Statement on Reverse Side)

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

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 *F. F. Walton*  
*F. F. Walton*

Licensed Embalmer No. *274*

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.