

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35984

State File No.

FILED NOV 21 1955

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

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1217</u>		
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>Jackson</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>23 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2.</u>				e. STREET ADDRESS (If rural, give location) <u>1115 Brooklyn</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u>			b. (Middle) <u>G.</u>		c. (Last) <u>Anderson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>November 15, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>March 24, 1884</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Linkoping, Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Carl August Anderson</u>			13b. MOTHER'S MAIDEN NAME <u>Emma L. Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Not Given Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. George Anderson Kansas City, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u>								<u>1 week</u>
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>				DUE TO (b) <u>Arteriosclerosis</u>				<u>10 years</u>
				DUE TO (c) _____				
11. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				<u>Psychotic</u>				<u>23 years+</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? _____				
22. I hereby certify that I attended the deceased from <u>11/12/1955</u> , to <u>11/15, 1955</u> , that I last saw the deceased alive on <u>11/14/1955</u> , and that death occurred at <u>8:20 A. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>G.E. Gossins M.D.</u>				23b. ADDRESS <u>State Hospital #2 St. Joseph, Mo.</u>		23c. DATE SIGNED <u>11/15/1955</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 16, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Carson Funeral Home</u>		24d. LOCATION (City, town, or county) (State) <u>Independence, Missouri.</u>			
DATE REC'D BY LOCAL REG. <u>Nov 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Eathan M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Meierhoffer - Fleeman, St. Joseph, Mo.</u>				

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 *Raymond J. Moore*.....
Licensed Embalmer No..... 4413.....

P. O. Address St. Joseph, Mo.....

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.