

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25898

STATE FILE NUMBER

6413

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No. 6413

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		Length of stay in 1b <b>7 months</b>	
25		22d. STREET ADDRESS <b>2519 W. St. Louis Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Darrell</b> Middle Last <b>Anderson</b>		4. DATE OF DEATH Month <b>7</b> Day <b>9</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1904</b>
9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist - Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (City and state or country) <b>Black Rock, Ark.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Anderson</b>	
14. MOTHER'S MAIDEN NAME <b>Rachel Matthews</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>497-09-2763</b>		17. INFORMANT Address <b>Mrs. Winifred Anderson 5313 Lucas-Hunt</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage;</b> <b>Fractured Ribs;</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>E978X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Suffered when thrown from balcony of first floor at City Hotel #1, and July 9, 1957. While suffering from a primary mental observation.</b>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT. <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. (18).) <b>1st floor at City Hotel #1, and July 9, 1957. While suffering from a primary mental observation.</b>		20c. TIME OF INJURY Hour <b>3</b> Month <b>7</b> Day <b>9</b> Year <b>57</b> a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>25 West</b>	
20f. CITY, TOWN, OR LOCATION <b>St Louis Mo.</b>		STATE <b>Missouri</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>12:30</b> <b>PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <b>James M Kelly Deputy</b>		22b. ADDRESS <b>1300 Clark</b>	
22c. DATE SIGNED <b>7-10-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE <b>7/11/57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>		ADDRESS <b>1905 Union</b>	
25. DATE RECD. BY LOCAL REG. <b>JUL 10 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b> <b>MDB</b>	

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be casually related. Coroner must certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Warren A. Carver*.....

Licensed Embalmer No. *34*

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.