

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39902

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1151-6

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>845 S. Newton</u>		d. STREET ADDRESS (If outside, give location) <u>845 S. Newton</u>	
Length of stay in 1b <u>60 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EARLE</u> Middle <u>GORDON</u> Last <u>ANDERSON</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1957</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1884</u>	9. AGE (In years last birthday) <u>72</u>	10. FUNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Fire Dept.</u>		11. BIRTHPLACE (City and state or country) <u>Halifax, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Roxana</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>493-36-8277A</u>		17. INFORMANT Address <u>Mrs. Roxana Anderson Springfield, Mo</u>			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1955</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (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) - <u>157X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
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20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
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21. I attended the deceased from <u>Oct. 1956</u> to <u>Nov. 29, 1957</u> and last saw him alive on <u>Nov. 29, 1957</u> Death occurred at <u>10:30</u> P. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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21a. SIGNATURE (Degree or title) <u>James E. Kuabert M.D.</u>		21b. ADDRESS <u>1630 N. Jefferson Springfield</u>		21c. DATE SIGNED <u>12/2/57</u>	
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22a. BURIAL, CREMATION, REBURY (Type) <u>Burial</u>		22b. DATE <u>Dec. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
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24. FUNERAL DIRECTOR <u>Ralph Thieme</u>		ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

OCT 23 1958

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 *Lee Mason* .....

Licensed Embalmer No. 4568

P. O. Address Springfield, 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.