

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022963
STATE FILE NUMBER

41721-1-7
FILED JUL 7 1958 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 166

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles Inside Limits Yes # No <input type="checkbox"/>		c. CITY OR TOWN St. Ann, Inside Limits Yes # No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital Length of stay in lb 1 Day		d. STREET ADDRESS 10817 St. Xavier La. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No # <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Anderson Last Anderson			4. DATE OF DEATH Month June Day 29 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) #####		10b. KIND OF BUSINESS OR INDUSTRY #####	9. AGE (In years last birthday) 0 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1
11. BIRTHPLACE (City and state or country) St. Charles Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Anderson		14. MOTHER'S MAIDEN NAME Dixie Street	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address Robert Anderson 10817 St. Xavier La.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Altered and Dilated, Congenital Heart Disease DUE TO (b) ③ Cerebral Edema DUE TO (c) ④ Hypoglycemia ② Severe Maternal diabetes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Maternal diabetes			INTERVAL BETWEEN ONSET AND DEATH 17 hrs 2 hrs 7691
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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.)		20c. TIME OF INJURY Hour 3 A M Month June Day 29 Year 1958	
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.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from June 28 to June 29 1958 and last saw her alive on June 29 1958 Death occurred at 3 A M m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul A. Waterhouse M D		22b. ADDRESS 10300 St. Charles Rd St. Louis County	
22c. DATE SIGNED June 29 1958		23. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 29, 1958	
23c. LOCATION (City, town, or county) St. Louis Mo.		23d. STATE Mo.	
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.		25. DATE RECD. BY LOCAL REG. JUNE 29-58	
26. REGISTRAR'S SIGNATURE Marella Wilson			

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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. Coroner cannot 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 *Sheldon Collier*.....

Licensed Embalmer No. *33*

P. O. Address *St. Am*

No Embalming

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