

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026712  
STATE FILE NUMBER

FILED JUL 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7059

S. 300

r. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hospitals, Inc.</b>		Length of stay in lb <b>54 days</b>	d. STREET ADDRESS (If outside, give location) <b>316 Greeley</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>G.</b> Last <b>Anderson</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1958</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>Sept. 15, 1883</b>		9. AGE (In years last birthday) <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>George G. Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Narcissa</b>	
14. NAME OF HUSBAND OR WIFE <b>Carrie Augusta Anderson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>702-14-0657</b>	
17. INFORMANT Address <b>Virginia Graff 2519 Ma. Holyoke Rd. Columbus</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>Cardiac failure, congestive</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>Anemia, nutritional</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Anemia, nutritional</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>Several years</b>			
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 Month, Day, Year 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>6/11/58</b> to <b>7/14/58</b> and last saw <sup>from</sup> him alive on <b>7/14/58</b> Death occurred at <b>8:15 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Robert C. Treuman M.D.</b>			22b. ADDRESS <b>1755 So. Grand Blvd.</b>		22c. DATE SIGNED <b>7/15/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 17, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries 6464 Chippewa St.</b>			25. DATE RECD. BY LOCAL REG. <b>7/16/58</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith mo</b> <b>mjb</b>

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.

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 *Lester C. Hoffmann*

Licensed Embalmer No. *3871*

P. O. Address *78148 Bu*

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.