Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-047218
STATE FILE NUMBER

Filed JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12821

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hosp. #1 — Length of stay in hospital: 21 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN ST.LOUIS,MO. — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 2747 Locust St. (If rural, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Nelson Middle Last Anderson

4. DATE OF DEATH: Month Dec. Day 19 Year 1958

5. SEX MALE 2
6. COLOR OR RACE NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9/12/1913
9. AGE (In years last birthday) 45 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN
11. BIRTHPLACE (City and state or country) ???
12. CITIZEN OF WHAT COUNTRY? 9

13a. FATHER'S NAME ??
13b. MOTHER'S MAIDEN NAME ??
14. NAME OF HUSBAND OR WIFE MARYBELLE WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT ST.LOUIS CITY HOSP , #1. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — Acute tubular necrosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive cardiovascular disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

ITEM 23a, 23b, 23c, 23d, 24 CORRECTED BY AFFIDAVIT OF Funeral Director 5-13-59

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Dec. 14, 1958, to Dec. 19, 1958 and last saw her/him alive on Dec. 19, 1958
Death occurred at 4:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph J. Burke M.D. (Degree or title)
22b. ADDRESS 1515 Lafayette Ave.
22c. DATE SIGNED 12/19/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE ~~JAN 5 1959~~ 5-6-59
23c. NAME OF CEMETERY OR CREMATORY ~~Anatomical Board~~ St. George Cemetery
23d. LOCATION (City, town, or county) (State) ~~St. Louis, Mo.~~ E. St. Louis, Ill.

24. FUNERAL DIRECTOR Andrew Burke ADDRESS 3506 Franklin ~~Rowland & Kiel 7104 Manchester~~
25. DATE RECD. BY LOCAL REG. JAN 15 59
26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.