

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009010

STATE FILE NUMBER

FILED APR 6 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 352

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1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo' b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 03960		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley		Length of stay in lb 52 yrs.	d. STREET ADDRESS (If outside, give location) 2343 Boonville Ave		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLAUDE Middle FREDERIC Last ANDERSON			4. DATE OF DEATH Month April Day 2 Year 1959		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 31 1906		9. AGE (In years last birthday) 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Springfield Mo'	12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME Frederic Anderson		13b. MOTHER'S MAIDEN NAME Mary Roberson		14. NAME OF HUSBAND OR WIFE Elizabeth Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) yes W.W.II		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Elizabeth Anderson Address 2343 Boonville St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage					INTERVAL BETWEEN ONSET AND DEATH About 20 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Portal Cirrhosis Liver					Don't know
DUE TO (c) 5810					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 4-1-59 to 4-2-59 and last saw her alive on 4-1-59 Death occurred at 5:30a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> (Degree or title)			22b. ADDRESS Medical Arts Bld'g		22c. DATE SIGNED 4-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 17 1959	23c. NAME OF CEMETERY OR CREMATORY Hazlewood Cemetery		23d. LOCATION (City, town, or county) (State) Springfield Mo'
24. FUNERAL DIRECTOR H.Y. Smith ADDRESS 602 N. Jefferson			25. DATE RECD. BY LOCAL REG. 4-3-59	26. REGISTRAR'S SIGNATURE Effie S. Orrellon	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

APR 28 1959
6553
APR 28

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 *Herbert V. Smith*

Licensed Embalmer No. *4256*

P. O. Address *Springfield*

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.