

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011576
STATE FILE NUMBER

FILED MAR 18 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 617

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN 4000 BELLEFONTAINE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Co. Hosp.		Length of stay in lb 6 HRS	d. STREET ADDRESS (If outside, give location) OLIVE ST. RD.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH L. ANDERSON			4. DATE OF DEATH Month Day Year 3 5 1959		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 22, 1883	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) ST. LOUIS Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME GOTTLIEB AMBRECHT	13b. MOTHER'S MAIDEN NAME ELIZABETH MUELLER	14. NAME OF HUSBAND OR WIFE ANDREW ANDERSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N/A.	16. SOCIAL SECURITY NO. N/A.	17. INFORMANT Aug. Albrecht, Chesterfield Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub. -dural and sub. -arachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) Traumatic head injury	
	DUE TO (c) Hypertensive cardiac-vascular disease	
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 checked="" 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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 **3-5-1959** to **3-5-1959** and last saw ^{her} ~~him~~ alive on **3-5-1959**
Death occurred at **1030 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John E. Oakley, M.D.	(Degree or title)	22b. ADDRESS 601 S. BRENTWOOD	22c. DATE SIGNED 3/6/59
---	-------------------	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 3/8/59	23c. NAME OF CEMETERY OR CREMATORY VALHALLA	23d. LOCATION (City, town, or county) (State) ST. CHARLES ROCK RD.
---	----------------------------	---	--

24. FUNERAL DIRECTOR SCHRAMMER F. H., BALLYWIN, MO.	25. DATE RECD. BY LOCAL REG. 3-7-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Richard Bopp*

Licensed Embalmer No. *4584*

P. O. Address *Ballwin, 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.