

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-018181
 STATE FILE NUMBER

FILED JUN 10 1959 Registration District No. 157 Primary Registration District No. 5585 Registrar's No. 109

300
 1-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Madison township		c. CITY OR TOWN Carthage	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rte 1 Carthage		Length of stay in lb 20 yrs.	
3. NAME OF DECEASED (Type or print) First JESSIE Middle CLERC Last ANDERSON		4. DATE OF DEATH Month May Day 30 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (City and state or country) Macon, Missouri
13a. FATHER'S NAME Jenks		13b. MOTHER'S MAIDEN NAME Eggleston	14. NAME OF HUSBAND OR WIFE John M. Anderson
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. none	17. INFORMANT Address John M. Anderson, Rte 1, Carthage, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 year.
DUE TO (b) Circulatory failure		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 334X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m.		
20d. INJURY OCCURRED WHILE AT <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 1956 to 1959-5-30 and last saw her alive on May 28, 1959 Death occurred at 5:00 a m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Dr. Verla Mettler	22b. ADDRESS D.C. 1710 S. Garrison, Carthage, Mo.	22c. DATE SIGNED 6-1-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-2-59	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery
		23d. LOCATION (City, town, or county) (State) Carthage, Missouri
24. FUNERAL DIRECTOR ADDRESS KNELL MORTUARY Carthage, Mo.	25. DATE RECD. BY LOCAL REG. 6-1-59	26. REGISTRAR'S SIGNATURE Elly Clutter

All diseases in Part I must be causally related.

VS JUN 15 1959

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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, M

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.