RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960 042

60-000261
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 112

DED

1. PLACE OF DEATH
a. COUNTY Buchanen
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Joseph
Length of stay in 1b: 22 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No,2
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo
b. COUNTY Buchanen
c. CITY OR TOWN St Joseph
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) In city
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)
First: LILLIE Middle: ELLEN Last: ANISER

4. DATE OF DEATH Month: 1- Day: 26 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-24-1899
9. AGE (last birthday): 61
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (City and state or country): Mo,
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Rubert Aniser
13b. MOTHER'S MAIDEN NAME: Mary Eirdanz
14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hospital record Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pulmonary Emphyseme — 6 Months
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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
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 1-22-60, to 1-26-60 and last saw her/him alive on 1-26-60.
Death occurred at 2.25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Mohammad Tahir M.D.
22b. ADDRESS State Hosp.#2 St Joseph Mo
22c. DATE SIGNED 1-26-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan.26,1960
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Maysville, Missouri

24. FUNERAL DIRECTOR Foley Bros Maysville Mo ADDRESS
25. DATE RECD. BY LOCAL REG.: Jan. 28, 1960
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF M. Tahir, M.D. 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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3933

P. O. Address Maysville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con
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.