

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		a. STATE Missouri COUNTY Franklin	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1.		c. CITY OR TOWN Lone Dell	
Length of stay in 1b		d. STREET ADDRESS (If outside, give location) Route #1	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) MABEL First ANDERECK Middle Last			4. DATE OF DEATH OCTOBER 20 1960 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1884	9. AGE (last birthday) 76	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 At home		11. BIRTHPLACE (City and state or country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME James Yowell		13b. MOTHER'S MAIDEN NAME Leolelia Eubanks		14. NAME OF HUSBAND OR WIFE Harry Andereck		

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. 1	17. INFORMANT Marjorie Asmus	Address 3203 Ashby St. Ann, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 2 wks
IMMEDIATE CAUSE (a)	Cerebro vascular accident	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Arteriosclerosis generalize	
DUE TO (b)	331X	?
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from SEPTEMBER 30, 1960 to OCTOBER 20, 1960 and last saw her alive on OCTOBER 20, 1960	
Death occurred at 2:53A m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Paul Mennen M.D.	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED 10/20/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-22-60	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. MO.
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24. FUNERAL DIRECTOR Earl Hilleman	ADDRESS Overland, Missouri	25. DATE RECD. BY LOCAL REG. OCT 20 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
Signature of Student Embalmer

Signed Earl F. Hillman

Licensed Embalmer No. 3501

P. O. Address Overland

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