

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 24 1961

-61-001211

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 54 STATE FILE NUMBER

DATE AMENDED
 AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 50 YRS.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1417-E-16		d. STREET ADDRESS (If outside, give location) 1417-E-16	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ALBERT ANDERSON		4. DATE OF DEATH Month Day Year 1-2-1961	
5. SEX COLOR OR RACE MALE COLORED		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 1-1-1890		9. AGE (last birthday) 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (City and state or country) CROCKETT, TEXAS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME DON'T KNOW		13b. MOTHER'S MAIDEN NAME DON'T KNOW	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.I	
16. SOCIAL SECURITY NO.		17. INFORMANT Address CARL MULLIN, K.C., 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) Chronic Myocarditis DUE TO (b) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input 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 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	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Deputy Coroner		22b. ADDRESS 1618 Lydia Ave	
22c. DATE SIGNED 1/3/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 1-9-1961	
23c. NAME OF CEMETERY OR CREMATORY NATIONAL		23d. LOCATION (City, town, or county) (State) FT. LEAVENWORTH, KS.	
24. FUNERAL DIRECTOR ADDRESS BROWN-HUDSON, K.C., MO.		25. DATE RECD. BY LOCAL REG. 1-6-61	
26. REGISTRAR'S SIGNATURE Ruth Long			

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 Millard B Paskin

Licensed Embalmer No. 5013

P. O. Address H.C.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.