

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-011838

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 872

FILED APR 10 1961

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 Normandy	Length of stay in 1b 7 Days	c. CITY OR TOWN Overland	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10593 Clarendon	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Anderson			4. DATE OF DEATH Month March Day 29 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1961	9. AGE (last birthday) NB	IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 24 HR Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Normandy, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Cleo Gene Anderson		13b. MOTHER'S MAIDEN NAME Maddline Beatrice Porter		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) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT Medical Record.	Address
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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
IMMEDIATE CAUSE (a) Cardio-Respiratory failure.		2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Sepsis (Intrauterine?)	8 days
	DUE TO (c) Prematurity	8 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Gastrointestinal Hemorrhage		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	
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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.)	
20c. TIME OF INJURY Hour 11:35 P. Month, Day, Year 3-29-61			

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 Overland	COUNTY Clarendon	STATE Mo.
21. I attended the deceased from 3-22-61 to 3-29-61 and last saw her/him alive on 3-29-61 . Death occurred at 11:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Monty L. Richardson	22b. ADDRESS 9553 Larchland Rd	22c. DATE SIGNED 3-30-61
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23a. FULL CREMATION (If cremated, give date) 3/30/61	23b. DATE	23c. NAME OF CEMETERY OR CREMATOR ST. MATTHEWS	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
24. FUNERAL DIRECTOR COLLIER, MORTUARY	ADDRESS ST. ANN	25. DATE RECD. BY LOCAL REG. 3-30-61	26. REGISTRAR'S SIGNATURE John G. Murphy

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student

No Embalming
Signature of Student Embalmer

Signed

J. J. Johnson
No Embalming

Licensed Embalmer No.

3382

P. O. Address

St. Ann

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.