

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035924

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042 Primary Registration District No. 1000 Registrar's No. 1112

STATE FILE NUMBER

AMENDED

Registration District No. **FILED NOV 13 1961**

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| 1. PLACE OF DEATH a. COUNTY Euchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Euchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in lb Life | c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 422 1/2 South 6th St., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Nellie Middle Last Anderson | | | 4. DATE OF DEATH Month October Day 28 Year 1961 | |
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| 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 May 22, 1907 | 9. AGE (last birthday) 54 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
|-------------------------|----------------------------------|---|---|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (City and state or country) St. Joseph, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME William A. Cox | 13b. MOTHER'S MAIDEN NAME Mable Matilda | 14. NAME OF HUSBAND OR WIFE Walter A. Anderson |
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| 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. unknown | 17. INFORMANT Ertha Squire, St. Joseph, Missouri | 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: IMMEDIATE CAUSE (a) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. |
| DUE TO (b) Congestive Heart Failure | | 2 wks. |
| DUE TO (c) | | |

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| 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 type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) |
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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 10-16-61 to 10-27-61 and last saw her/him alive on 10-27-61 Death occurred at 1:45 A. M. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) Wm. J. Craig M.D. | 22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo. | 22c. DATE SIGNED 10-30-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE Oct. 31, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Sunbridge Cemetery | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
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| 24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Nov. 8, 1961 | 26. REGISTRAR'S SIGNATURE Wm. Clark Handell |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

NOV 16 1961

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 *Eric J. Conway*

Licensed Embalmer No. 4679

P. O. Address St. Joseph, Mo.

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.