

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032231

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8332 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 31 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		c. CITY OR TOWN <u>Saint Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5560 Pershing</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILA</u> Middle <u>ANDERSON</u> Last						4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1962</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/1885</u>		9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>John Wesley Renard</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>William T. Anderson, late</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Marguerite C. Metz 5560 Pershing</u>					
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) <u>Myocardial ischemia</u>										<u>1 1/2 hr</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) <u>Coronary atherosclerosis</u>										<u>1 1/2 hr</u>	
DUE TO (c) <u>arterio sclerotic heart disease</u>										<u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary embolism</u>								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			
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.) <u>4200</u>							
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>aug 17-62</u> to <u>aug 25-62</u> and last saw her/him alive on <u>aug 25, 1962</u> Death occurred at <u>7 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>						22b. ADDRESS <u>57 Maryland Ave</u>			22c. DATE SIGNED <u>8/27/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>8/28/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maywood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Maywood, Missouri</u>		23e. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24. FUNERAL DIRECTOR <u>Lupton Chapel inc 7233 Delmar Blvd</u> ADDRESS						25. DATE RECD. BY LOCAL REG. <u>AUG 27 1962</u>		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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Anderson City

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Dr. Sam Pranger  
52 Maryland Plaza  
Fo-1-3062

**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 Clarence A. Murray

Licensed Embalmer No. 4011  
P. O. Address St. Louis, 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.