

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012977

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

3474

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

FILED APR 8 1963

1. PLACE OF DEATH
 a. COUNTY **4921 Suburban Tracks**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in lb
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **4921 Suburban Tracks** Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **MO.** b. COUNTY

3. NAME OF DECEASED (Type or print) First **Julia** Middle Last **Anderson** 4. DATE OF DEATH Month **3** Day **24** Year **63**

5. SEX **Female** 6. COLOR OR RACE **Negro** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **5-6-1886** 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) 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Grant County Ark.** 12. CITIZEN OF WHAT COUNTRY **U.S.A**

13a. FATHER'S NAME **George Anderson** 13b. MOTHER'S MAIDEN NAME **Elisa Reliford** 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (no, no, or unknown) (If yes, give war or dates of service) **No** 17. INFORMANT Address **Vernia Mae Carpenter 1 Same**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Cerebral Hemorrhage 1 day**
 DUE TO (b) **Hypertensive Heart Disease - 6 mos**
 DUE TO (c) **443X**
 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **Oct 17, 1962 to 3/24/63** her last seen alive on **3/24/63**
 Death occurred at **8:30 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **A. E. Hale M.D.** 22b. ADDRESS **822 N. Jefferson** 22c. DATE SIGNED **3/25/63**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Shipped** 23b. DATE **3/28/1963** 23c. NAME OF CEMETERY OR CREMATORY **Knight of Phytians** 23d. LOCATION (City, town, or county) (State) **Jonesboro Ark**

24. FUNERAL DIRECTOR ADDRESS **Hill & Radford 1713 N Grand** DATE RECD. BY LOCAL REG. **MAR 26 1963** 26. REGISTRAR'S SIGNATURE **Loan Smith. M.D.**

STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 Leroy W. Sannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.