

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

APR 26 1935

8501

1. PLACE OF DEATH
 County Cole Registration District No. 211
 Township Centertown Primary Registration District No. 4128
 City Centertown (No. 1) St. _____ Ward) _____
 2. FULL NAME Millard Fillmore Anderson
 (a) Residence, No. Centertown Mo. Ward. _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 11 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ora Ann Gregory
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 16 - 1863
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 00 26
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Blacksmith
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Self
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticello Mo
 FATHER 13. NAME Alex Anderson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No information
 MOTHER 15. MAIDEN NAME My
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No
 17. INFORMANT (ADDRESS) Mrs M Anderson Centertown
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Centertown Mo Feb 15 - 1935
 19. UNDERTAKER (ADDRESS) Lawson - James
 20. FILED 3/15/35 H. J. Beach, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 12 1935
 22. I HEREBY CERTIFY, That I attended deceased from 3/3/35, 1935, to 3/12/35, 1935.
 I last saw him alive on 3/10/35. Death is said to have occurred on the date stated above, at 10:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Nephritis, Chronic
Interstitial
 Date of onset _____
121
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
Jefferson City Mo

