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Dr. Bruce  
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State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3014

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City, Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: t. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether years, months or days)

In this community 3 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

(c) City or town Jefferson City, Missouri  
(If outside city or town limits write "RURAL")

(d) Street No. 414 East McCarty Street  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mrs. Regina Anderson 536

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife William E. Anderson

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased August 15th 1891  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>10</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace Westphalia, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name James M. Copeland

13. Birthplace Maries County, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Elizabeth Crum

15. Birthplace Maries County, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. E. Anderson

(b) Address Jefferson City, Missouri

17. (a) Burial (b) Date thereof July-11-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Easton, Missouri

18. (a) Signature of funeral director Spork of Gordon

(b) Address Jefferson City, Missouri

19. (a) 7/11/40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year 1940 hour am minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from June 10 1940 to July 9 1940  
that I last saw her alive on July 9 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Brown Tumor

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: Of operations \_\_\_\_\_

Of autopsy Brown Tumor Right Parietal

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

40 Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? III

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD  
Address Jefferson City, Mo Date signed July 11/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

55R

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Roy J. Gordon*

Licensed Embalmer No. *1786*

P. O. Address *Jefferson City 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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24949**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Cole**  
(b) City or town **Jefferson city**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME **Mrs Regina Anderson**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **7** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **48** Months **10** Days **24** If less than one year \_\_\_\_\_ min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **9** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Tumor** Duration \_\_\_\_\_

Due to **Secondary to Uterine Carcinoma**

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death) **48**

Major findings. Of operation **Brain Tumor, Right Parietal, malignant**

Of autopsy **Right**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature **J. E. Stacey** (M.D. or other)

Address **Jefferson City**

SUPPLEMENTARY

