

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

41535

Registration District No.

Primary Registration District No.

Registrar's No.

3

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Harto Run
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone Cole
(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")
(d) Street No. 414 East McCarty Street
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Edward Anderson

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Regina Anderson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 24 1891
(Month) (Day) (Year)

8. AGE: Years 52 Months 5 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation Mechanic

11. Industry or business _____

12. Name Millard Anderson
13. Birthplace Moniteau County, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Ora Gregory
15. Birthplace Moniteau County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant W. E. Anderson Jr.
(b) Address 3017 Benton, Kansas City, Mo

17. (a) Burial (Burial, cremation, or removal) Scenectertown, Missouri
(b) Date thereof Dec-15-1943
(Month) (Day) (Year)

18. (a) Signature of funeral director Thos J Gordon
(b) Address Jefferson City, Missouri
19. (a) 12-30-43 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 13 year 1943 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from Nov 28 to Dec 13 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Heart failure
Due to: operation for carcinoma of left colon

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations [Signature]

Of autopsy _____

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 [Signature] (M. D. or other) _____
Address [Signature] Date signed 12-18-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

JAN 12 1968

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 *Thos J Gordon*
Licensed Embalmer No. *1286*
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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 3

Registration District No. 30 Primary Registration District No. 4066

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

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Near Hartsburg, Mo
(If outside city or town limits, write "RURAL" and name of township)
(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 about a week. years, months or days)

3. (a) PRINT FULL NAME Wm. E. Anderson

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 24 (Month) (Day) (Year)

8. AGE: Years 52 Months _____ Days _____ (If less than one day) _____ 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-14-44 (Date received local registrar) (b) N. G. Meyers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cole
(c) City or town Jefferson City (If outside city or town limits, write "RURAL")
(d) Street No. 14 E. McPartey (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or/No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

S 41535