N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

5281

County Audrain

Township Prairie or Village or City ____ (No. ____ St.; ____ Ward)

Registration District No. 24

Primary Registration District No. 4018

File No. ____

Registered No. ____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jas Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

DATE OF BIRTH: Feb (Month) 13 (Day) 1841 (Year)

AGE: 75 yrs. ____ mos. 1 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): "

BIRTHPLACE (City or town, State or foreign country): Montgomery Co.

PARENTS

NAME OF FATHER: Jim Anderson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky

MAIDEN NAME OF MOTHER: Rhoda Manning

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unk

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs B Anderson

(ADDRESS) Laddonia Mo.

Filed Feb 16. 1916. T M Monroe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 14 (Day) 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 11, 1916, to Feb 14, 1916, that I last saw h[illegible] alive on Feb 14, 1916, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows: Valvular Heart Lesion

(Duration) 5 yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W E Comett M. D.

Feb 14 1916 (Address) Rushville mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Hurley Chapel

DATE OF BURIAL: Feb 16 1916

UNDERTAKER: D G Granger

ADDRESS: Laddonia Mo

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St.: ..... Ward) [If dea
hospital
give its
of street

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) (D

I HEREBY CERTIFY, that I attended de
....., 191...., to.....
that I last saw h.....alive on.....
and that death occurred, on the date stated above,
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mo

Contributory.....
(SECONDARY)
.....(Duration).....yrs.....mo

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violen
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TI
RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....m

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BI
UNDERTAKER	**ADDRESS**

Revised United States Standard Certificate of Death