

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
County Fellis

Township _____
or
Village _____
or
City Sedalia (NO. _____)

Registration District No. 668

File No. 7067

Primary Registration District No. 3032

Registered No. 40

St. _____ Ward _____

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

FULL NAME Richard Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White ~~SINGLE~~ Married
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(If write the word)

DATE OF BIRTH Dec 26, 1937
(Month) (Day) (Year)

AGE 80 yrs. 1 mos. 5 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) County Kerry Ireland

PARENTS
NAME OF FATHER Richard Anderson
BIRTHPLACE OF FATHER Ireland
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Dora Prior
BIRTHPLACE OF MOTHER Ireland
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will A. Scallan

(ADDRESS) 602 So Main

Filed Feb 2 197 H. B. Jones REGISTRAR

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

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb - 1, 197
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 31, 197, to Jan - 31, 197,
that I last saw him alive on Jan - 31, 197,
and that death occurred, on the date stated above, at 1:30 p.m.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis

Contributory (SECONDARY) Age
(Duration) _____ yrs. _____ mos. _____ ds.
(Slashed) 97 162
(Address) Sedalia 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 Catholic DATE OF BURIAL 1-3, 197

UNDERTAKEN McKenzie ADDRESS Sedalia

PLACE OF DEATH

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

County _____

Township _____
or _____Village _____
or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____ Ward _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (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)

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) _____ (Day) _____ (Year) 191 _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____,

that I last saw h. alive on _____, 191 _____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

M. D.

(Address) _____

* 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 _____

DATE OF BURIAL _____

UNDERTAKER _____

ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.