

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 Shelby
Township Blackhawk
or
Village Shelbyville
or
City _____

Registration District No. 881
Primary Registration District No. 4504

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH **33971**

File No. _____
Registered No. 27

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

FULL NAME Julius Pictor Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH March 17, 1842
(Month) (Day) (Year)

AGE 75 yrs 6 mos 10 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Fanner
(b) General nature of industry, business, or establishment in which employed (or employer) 131

BIRTHPLACE
(City or town, State or foreign country) Sweden 137

PARENTS
NAME OF FATHER Doc. Anderson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden
MAIDEN NAME OF MOTHER Lilla Anderson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sweden

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Wright
(ADDRESS) Emden Mo
Filed Sept 25 1917 W. Carson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 25, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 23, 1917, to Sept. 25, 1917, that I last saw him alive on Sept. 25, 1917, and that death occurred, on the date stated above, at 230 p.m.

The CAUSE OF DEATH was as follows:
Chronic interstitial nephritis

1/20 (Duration) 9 yrs. X mos. 2 ds.

Contributory Hypertrophy of Prostate
(SECONDARY) (Duration) 8 yrs. X mos. X ds.

(Signed) P. C. Archer M. D.
Sept 25, 1917 (Address) Shelbyville 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 Shelbyville, Dec. 26, 1917 DATE OF BURIAL Sept. 26, 1917

UNDERTAKER J. N. Thompson & Sons ADDRESS Shelbyville, Mo.

PLACE OF DEATH

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

County _____

Township _____ or Village _____ or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(If death occurred in hospital or in nursing home, give its NAME and address of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	DATE OF DEATH	
	SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word)		(Month) (Day)
DATE OF BIRTH		I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, that I last saw him _____ alive on _____ and that death occurred, on the date stated above, at _____	
AGE		The CAUSE OF DEATH* was as follows:	
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) _____			
PARENTS			
BIRTHPLACE OF FATHER			
(City or town, State or foreign country)			
MAIDEN NAME OF MOTHER			
BIRTHPLACE OF MOTHER			
(City or town, State or foreign country)			
CONTRIBUTORY			
(SECONDARY)			
(Signed) _____			
191____ (Address) _____			
*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RESIDENTS)			
At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____			
Where was disease contracted if not at place of death? _____			
Former or usual residence _____			
PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL	
UNDERTAKER		ADDRESS	
Filed _____, 191____		REGISTRAR	

"Typhoid pneumonia"; Lobar pneumonia; Broncho-