

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.

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

PLACE OF DEATH Camden
County Osage
Township Osage
or
Village
or
City

Registration District No. 117
Primary Registration District No. 5167

File No. 13 **38419**
Registered No.

FULL NAME Andy Anderson (NO. St. Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(If wife the word)

DATE OF BIRTH March 15, 1883
(Month) (Day) (Year)

AGE 35 yrs. 7 mos. 24 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) Camden Co Mo

PARENTS
NAME OF FATHER Chas Anderson
BIRTHPLACE OF FATHER Indiana
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Joe Garrison
BIRTHPLACE OF MOTHER Camden Co Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Anderson
(ADDRESS) Camden Co Mo

Filed Nov 25, 1918 Registrar
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 9, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 25, 1918, to Nov 9th, 1918, that I last saw him alive on Nov 9th, 1918, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Influenza)
10 days (Duration) 10 yrs. 10 mos. 10 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Geo. W. McFar M. D.
Nov 9, 1918 (Address) Camden Co 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 Union Cemetery DATE OF BURIAL Nov 12, 1918

UNDERTAKER Anderson & Sons ADDRESS Richland

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

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

St. _____ Ward _____

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 _____, 191____ (Month) _____ (Day) _____ (Year)

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) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

(Address) _____, 191____

* 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. 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

191____