LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County: Lawrence
Township: Pierce
or
Village:
or
City: ~~Monett~~ (NO. ..... St. ..... Ward)

Registration District No. 471 File No. 3 7621
Primary Registration District No. 5634 Registered No. 72

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

2 FULL NAME: Carl Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept 7 (Month) (Day) 1912 (Year)

7 AGE: 7 yrs. 5 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCUPATION
(a) Trade, profession, or particular kind of work: Oiler
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Monett Mo

PARENTS
10 NAME OF FATHER: Will W Anderson
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Missouri
12 MAIDEN NAME OF MOTHER: Arty Wolfford
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W W Anderson
(Address): Monett Mo

15 Filed 2/25, 192 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 16th, 1920, to Feb, 1920, that I last saw him alive on Feb 22, 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
11A
10
(Duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary): Influenza
(Duration) yrs. mos. 8 ds.
(Signed): C. T. Greenberry M. D.
2-24, 1920 (Address): Monett Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Anderson Cem
DATE OF BURIAL: 2/26, 191
20 UNDERTAKER: [illegible]
ADDRESS: Monett

N. B.—Every item of information should be carefully supplied. Avoid words or abbreviations. Write plainly. Do not use ditto. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township..... or Village ..... or City..... (NO....., ...St.:.....Ward)

Registration District No..... Primary Registration District No. .....

File No. ..... Registered No. .....

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | **4 COLOR OR RACE** | **5 SINGLE MARRIED WIDOWED OR DIVORCED** (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191..... (Month) (Day) (Year)

17 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.

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

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191.....

20 UNDERTAKER | **ADDRESS**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.