NOV 23 1927 95

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

Do not use this space.

29574

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No.
Township — Primary Registration District No. 1001 — Registered No. 1628
City St Joseph (No. ..... St. ..... Ward)

2. FULL NAME Arthur J. Anderson
(a) Residence. No. State Hospital #2 St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 11 mos. 9 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR): About 1885

7. AGE: Years 42 Months Unknown Days — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: T. A. Humphrey
(Address) Lathrop Mo

15. FILED OCT 10 1927 19 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 6. 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27. 1925, to Oct. 6. 1927, that I last saw him alive on Oct. 6. 1927, and that death occurred, on the date stated above, at 2:55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of Insane
83
34 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Syphilis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) J. R. Bunch, M. D.
10/6/ 1927 (Address) State Hospital #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: State Anatomical Board — DATE OF BURIAL: 10-12-1927

20. UNDERTAKER: Fred D. Clark — ADDRESS: 5025 King Hill

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.