

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

Do not use this space.

31956

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No. 1806 Pajar) St. 2nd Ward.

File No.
Registered No. 19323
St. Ward)

2. FULL NAME

Anderson Gust
(a) Residence. No. 1806 Pajar St. 2nd Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 3-1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 | 4 | 11 | 0 | 0 | 0

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) Miss
(STATE OR COUNTRY)

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

14. INFORMANT Lee Anderson
(Address) 210 E Pa 23 St

15. FILED OCT 20 1927 Man. C. Starkeff
19 27 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 14 19 27

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131
23 (duration) yrs. mos. da.
CONTRIBUTORY Chronic Bronchopneumonia
(SECONDARY) Hepatitis da.

18. WHERE THE DISEASE CONTRACTED W. M. A.
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

19. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. M. Heber M.D.

10/19/27 (Address) Deputy Comm
*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 Father's Burial DATE OF BURIAL Oct 22 1927

20. UNDERTAKER Watson and Son ADDRESS 2944 Chouteau

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.

