

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

Do not use this space.

**32883**

**1. PLACE OF DEATH**

County Calloway  
Township Fulton  
City Fulton (No. ....) St. .... Ward)

Registration District No. 104  
Primary Registration District No. 3008

File No. ....  
Registered No. 229  
St. .... Ward)

**2. FULL NAME**

Louis Anderson

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) AK

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
Act 36 | AK

8. OCCUPATION OF DECEASED None

- (a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Don't know  
(STATE OR COUNTRY)

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know  
(STATE OR COUNTRY)

14. INFORMANT Hospital  
(Address)

15. FILED Nov 27 1927 A. N. Crew  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-29 1927

17. I HEREBY CERTIFY, That I attended deceased from 10-21 1927, to 11-19 1927  
that I last saw him alive on 11-19 8:45 P.M. 1927, and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Summ of stroke

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

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) A. B. Remley M. D.  
11-19 1927 (Address) Fulton Mo

\*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 Lexington Mo. DATE OF BURIAL D.K. 19

20. UNDERTAKER Hendon Taylor ADDRESS FULTON MO.

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.

DEPARTMENT RECORD

