

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

Do not use this space.

33634

1. PLACE OF DEATH

County Jackson Registration District No. 3002 File No. _____
Township Raw Primary Registration District No. Regent Hosp Registered No. 4404
City Kansas City (No. 40) North Davenport Rd. (Ward)

2. FULL NAME

John W Anderson
(a) Residence No. 40 N Davenport Rd 4 Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18-1855

7. AGE YEARS MONTHS DAYS 64 1 6 1 If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(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) Mo.

10. NAME OF FATHER John W Anderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Mary Owens

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT Addie May Anderson
(Address) 40 N Davenport Rd.

15. FILED 11-20-27 M. M. Crovere REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14 1927

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute mobile thrombosis
of skull fractured
for 6 mo
910M (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 1800 (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? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) R. E. Thoma, M. D.

11-19, 1927 (Address) Coroner

*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 Not buried DATE OF BURIAL Nov 22 1927

20. UNDERTAKER D. W. Newsom's Sons ADDRESS 2115 69th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

M. R.—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.

JUN 2 1955