

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

Do not use this space.

1071

1. PLACE OF DEATH

County Jackson
Township Law
City Haus City Mo. (No.)

Registration District No. 399
Primary Registration District No. 1907

File No. 91
Registered No.
St. (Ward)

2. FULL NAME

Robert P. Anderson

(a) Residence. No. 3943 Bellefontaine 16 Ward. (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 47 3 1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work office work
(b) General nature of industry, business, or establishment in which employed (or employer) White Eagle Oil Co
(c) Name of employer Stellonville

9. BIRTHPLACE (CITY OR TOWN) Stellonville
(STATE OR COUNTRY) Maine

10. NAME OF FATHER Capt. H. M. Anderson

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

12. MAIDEN NAME OF MOTHER Clara E. Johnson

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

14. INFORMANT Mrs Mornie Anderson
(Address) 3943 Bellefontaine

15. FILED Jan 9 28 M. M. Casper REGISTRAR Casper

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 28

17. I HEREBY CERTIFY, that I attended deceased from , 1928 to , 1928, and that I last saw h. alive on , 1928, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial infarction
heart
90 W (duration) yrs. mos. ds.

CONTRIBUTORY adherent Pericarditis
(SECONDARY) (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? yes

WHAT TEST CONFIRMED DIAGNOSIS? gulf
(Signed) W. W. Newcomer, M.D.
1/8, 1928 (Address) Liberty Corner

*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 Forest Hill DATE OF BURIAL 1/9 1928

20. UNDERTAKER D. W. Newcomer Sons ADDRESS J.C. Mo.

I. 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.

