

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

Do not use this space.

1207

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City (No. 2, 208)

Registration District No. 299
Primary Registration District No. 1002

File No. _____
Registered No. 231
St. _____ Ward _____

2. FULL NAME

Olaf Andrew Anderson

(a) Residence No. 2208 Lister St. 13 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. 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 Mollie G. Anderson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1861

7. AGE YEARS 67 MONTHS _____ DAYS 17 IF LESS than 1 day, hrs. or min.

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

10. NAME OF FATHER Olaf Anderson

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

12. MAIDEN NAME OF MOTHER not known

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

14. INFORMANT Rev G. Anderson (Address) 2208 Lister

15. Jan 18, 28 M.M. Levine REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1928 to Jan 17 1928 that I last saw him alive on Jan 16 1928, and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
121 1/2 1929
1000 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) Thromic Intestinal nephritis
Hypertension (duration) ? yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory & B.P. test
(Signed) D. DeLeonardis, M.D.
1/18, 1928 (Address) 4805 Grand St

*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 Cem DATE OF BURIAL Jan 19 1928

20. UNDERTAKER John W Wagner ADDRESS 1409 Grand Ave

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.

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