MAR 21 1928

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

Do not use this space.

11906

1. PLACE OF DEATH
County Scott Registration District No. 87
Township Richland Primary Registration District No. 6070 File No. 18
City New Crawford (No. ..... St. ..... Ward) Registered No. .....

2. FULL NAME Evan Anderson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Colored	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17 1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
		9	14	

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

9. BIRTHPLACE (CITY OR TOWN) Scott Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Isom Anderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tennessee
12. MAIDEN NAME OF MOTHER Lodie Farris
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Monroe Co
(STATE OR COUNTRY) Ark

14. INFORMANT Evan Anderson
(Address) Wayne Route 2

15. Filed 3/6/28 W. D. Wilson REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 1 1928

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 3.00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
IA
IB
IC IIA
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Influenza
(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) W. D. Wilson Coroner Scott Co
3/2, 1928 (Address) Sikeston Mo M.D.

*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 Carpenter — DATE OF BURIAL 3/2 1928

20. UNDERTAKER Nance — ADDRESS .....

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.