

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

Do not use this space.

22598

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 003  
 City St. Louis, (No. St. Lukes Hospital) Registered No. 6827 (Ward)

**2. FULL NAME**

Florence N. Anderson  
 (a) Residence. No. # 4944 McPherson Ave. (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 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 John W. Anderson  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 12 - 1875  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 52 9 16  
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work at home  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY)

**PARENTS**  
 10. NAME OF FATHER James B. Newby  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 12. MAIDEN NAME OF MOTHER Lebia A North  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT John W. Anderson (Address) # 4944 McPherson Ave.

15. FILED A 29 W. C. Staley REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28, 1928  
 17.

I HEREBY CERTIFY, That I attended deceased from May 22, 1928, to June 28, 1928, that I last saw him alive on June 28, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Septicemia  
1333  
36 (duration) yrs. mos. 3 ds.  
 CONTRIBUTORY (SECONDARY) Relapsing fever (duration) yrs. mos. 9 ds.  
(Rt. Pyelitis)  
Operation for calculus of kidney non  
 WHERE WAS DISEASE CONTRACTED Tubercular cause unknown  
 IF NOT AT PLACE OF DEATH.

18. DID AN OPERATION PRECEDE DEATH? Yes DATE OF June 26 - 27

19. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Tub. spec. + autopsy  
 (Signed) J. D. Johnson, M. D.  
 (Address) 29 28 Liberty Blay

\*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, DATE OF BURIAL  
Grays Summit, Mo. 6-30-1928

20. UNDERTAKER ADDRESS  
L. R. Davenport 4449 Olive Street

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.

2000 R. 27  
S. 1