

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

Do not use this space.

31897

**1. PLACE OF DEATH**

County..... Registration District No.....  
Towship *St. Louis Mo.* Primary Registration District No.....  
City *St. Louis Mo.* No. *2918 Nebraska*

File No.....  
Registered No. *9157*  
St..... Ward.....

**2. FULL NAME**

*Frederick W. Anderson*  
(a) Residence No. *2918 Nebraska Ave.*, St., *23* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 10 - 1857*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*71* | *7* | *3* | |

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *House Wife*  
(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) *St. Louis Mo.*

**10. NAME OF FATHER**

*Christ Schmidt*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Germany*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Germany*

**14.**

INFORMANT *August Anderson*  
(Address) *6048 Mc Cune*

**15.**

FILED *10 1922* *Max C. Starker*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 13 - 1928*

17. I HEREBY CERTIFY That I attended deceased from *Aug 2*, 19*28*, to *Sept 13*, 19*28*.  
that I last saw *him* alive on *Sept 12*, 19*28*, and that death occurred, on the date stated above, at *3:11* p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*apoplexy (Cerebral) Hemorrhage*

CONTRIBUTORY (SECONDARY) *Nephritis (Chronic Interstitial)*

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

1) DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical + Laboratory*

(Signed) *H. C. Cawley*, M. D.  
*9/13*, 19*28* (Address) *6460 Hawthorn Ave*

\*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**

*St. Matthews Cem.* *9-15-1928*

**20. UNDERTAKER**

**ADDRESS**

*Ziegenhein Bros. 26236 Nebraska*

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.

