

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

Do not use this space.

102

1. PLACE OF DEATH

County Burney Registration District No. 37 File No. _____
 Township Washington Primary Registration District No. 3033 Registered No. _____
 City _____ (No. _____ Anderson St. _____ Ward)

2. FULL NAME

Charity 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
80 7 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Penn
 (STATE OR COUNTRY)

10. NAME OF FATHER Gas Wash

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

12. MAIDEN NAME OF MOTHER Garber

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

14. INFORMANT J. Breed
 (Address) Washington

15. FILED 1/19/99 19 99 J. S. Haskett
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 19 24

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 Jan 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11/15 with infarction of angle
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 11/15
 (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) J. S. Haskett, M. D.
 _____, 19____ (Address) Seligman Dr

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Nickles Cemetery DATE OF BURIAL Jan 14 19 24

20. UNDERTAKER Dugan Loney ADDRESS _____

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

234
2
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2

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Barry Registration District No. 37 File No.
 Township Washington Primary Registration District No. 5753 Registered No.
 City (No.) St. Ward)

2. FULL NAME Charity 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 F **4. COLOR OR RACE** W. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** W. (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1848

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
80 7 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 12/29 1919 J. S. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1929

17. I HEREBY CERTIFY That I attended deceased from
 , 19....., 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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)....., M. D.

, 19 (Address)

*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**

20. UNDERTAKER J. S. [Signature] **ADDRESS** [Address]

N. P. Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. STRAVERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

102