APR 24 1929

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

Do not use this space.

10130

1. PLACE OF DEATH
County Dent Registration District No. 266 File No. 87
Township Spring Creek Primary Registration District No. 4164 Registered No. 87
City Salem (No. St. Ward)

2. FULL NAME Mary Elizabeth 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 7 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): Widow

5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of: widow of Jerry Anderson

6. DATE OF BIRTH (month, day and year): Dec 22 – 1848

7. AGE: Years 80 Months 3 Days 6 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(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): Indiana

PARENTS
10. NAME OF FATHER: Christian Schafer
11. BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14. INFORMANT: Marian Anderson
(Address): Salem Mo

15. FILED 3/29, 1929 W. E. Rudd, M.D., REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year): Mch. 28th 1929

17. I HEREBY CERTIFY, That I attended deceased from Mch 28, 1929, to 3/28, 1929, that I last saw her alive on 3/28, 1929, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* was as follows:
Myocarditis chronic
(duration) 2 yrs. – mos. – ds.

CONTRIBUTORY (SECONDARY) General Debility & Senility (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual Physical
(Signed) W. E. Rudd, M.D.
, 19 (Address) Salem, Mo.

*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: Green Forest
DATE OF BURIAL: 3/31 1929

20. UNDERTAKER: N. D. Hobson
ADDRESS: Salem Mo

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.

11 235 2 10 31

[illegible] be carefully applied. [illegible] should [illegible] A [illegible]
[illegible] that [illegible] may be properly [illegible]. Exc[illegible] [illegible] is very important.

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 Dent Registration District No. 266 File No. 10130
Township Primary Registration District No. 4164 Registered No. 47
City Salem (No. , St. Ward)

2. FULL NAME Mary Elizabeth 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)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22 - 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
X	79	3	6	

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)

PARENTS

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 3/29, 19 29 H. E. Rudel Co. Dr. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 28 1929

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 ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) ...yrs...mos...ds.

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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be stated EXACTLY. PHYSICIAN'S exact statement of OCCUPATION is required. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-10130