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

Do not use this space.

29323

File No. 8470

Registered No.

1. PLACE OF DEATH

County

Township St. Louis Mo

City (No. City Hospital #2 St. Ward)

Registration District No. 791

Primary Registration District No. 3093

2. FULL NAME John Anderson

(a) Residence (Usual place of abode) No. 3035 Lawton St., 21 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 14 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	Cl.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-1-1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	55	8	11	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Henry Anderson

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

12. MAIDEN NAME OF MOTHER Josephine Allen

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

14. INFORMANT A. Gertrude Creath

(Address) City Hospital #2.

15. FILED 19 Geo C. Vardell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-12 1929

17. I HEREBY CERTIFY, That I attended deceased from 7-21, 1929, to 8-12, 1929 that I last saw h. alive on 8-12, 1929, and that death occurred, on the date stated above, at 9 10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Prostate (duration) yrs. 4 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis

(Signed) H. H. Weathers, M. D.

8/12, 1929 (Address) City Hosp #2

*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
Washington Park	8/14 1929
20. UNDERTAKER	**ADDRESS**
Cooper Und. Co.	3100 Franklin

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.