

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.

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

Do not use this space.

1. PLACE OF BIRTH

County Macon
Township Chariton
City John Oliver Anderson (No. _____)

Registration District No. 529
Primary Registration District No. 5705

File No. 37743
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
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.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 2, 1874
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 4 28

8. OCCUPATION OF DECEASED

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

Randolph Co. Mo
Jerry Anderson

10. NAME OF FATHER

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

Howard Co. Mo

12. MAIDEN NAME OF MOTHER

Delpha Rice

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

Randolph Co. Mo

14.

INFORMANT M. P. Anderson
(Address) Jacksonville R. F. D.

15.

FILED Dec 3, 1929 J. L. Trippe M. D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Nov 30, 1929, that I last saw him alive on Nov 30, 1929, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

angina pectoris
7-11
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 89
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

8 IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. L. Trippe, M. D.
, 19 _____ (Address) College mound 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

DATE OF BURIAL

Wm. Salem Cem. Dec. 1, 1929

20. UNDERTAKER

ADDRESS

Kenner & Snow Jacksonville
Fla.

