

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

Do not use this space.

1818

191928
191931

1. PLACE OF DEATH

County Livingston Registration District No. 508 File No. _____
 Township _____ Primary Registration District No. 3026 Registered No. 134
 City Chillicothe (No. _____) St. _____ Ward _____

2. FULL NAME Ira Mae Anderson

(a) Residence. No. 216 Barnwell 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 Female 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) Mar. 20-29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
10 11

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) Chillicothe Mo.

10. NAME OF FATHER Forest Anderson

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

12. MAIDEN NAME OF MOTHER Missie Bond

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

14. INFORMANT Martin Anderson (Address) Chillicothe Mo.

15. FILED 2/4/30 Clayton Parry REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 31 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Jan 31, 1930. That I last saw him alive on Jan 31, 1930, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
150 Erysipelas
Abdomen & legs
 (duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Physical symptoms

(Signed) W. C. Carter, M. D. (Address) Chillicothe 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 Hutchison beam DATE OF BURIAL Feb. 1 - 1930

20. UNDERTAKER Jas. D. Gordon ADDRESS Chillicothe

100-100000

100-100000

100-100000

**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 Livingston
Township Chillicothe
City Chillicothe (No., St. Ward)

Registration District No. 508
Primary Registration District No. 3026

File No.
Registered No. 134

2. FULL NAME

Iva Mae 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 S
(write the word)

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

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

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

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 6/9, 1930 Fulton Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1930

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:

Cryptosporidiosis
Abdomen & legs
Diapathy
(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

20. UNDERTAKER ADDRESS

REGISTR. TO RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED.

SUPPLEMENTARY