

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

Do not use this space.

13098

1. PLACE OF DEATH

County Johnson Registration District No. 426
Township Chilhowee Primary Registration District No. 5581
City Chilhowee (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____
St. _____ Ward 7

2. FULL NAME

James M. Anderson
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 54 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 1-1842

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	88	2	7	

8. OCCUPATION OF DECEASED

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

PARENTS	10. NAME OF FATHER <u>dont know</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>dont know</u>
	12. MAIDEN NAME OF MOTHER <u>dont know</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>dont know</u>

14. INFORMANT Sherman Anderson (Address) Chilhowee Mo

15. FILED 4/9 1930 J.B. Bouty REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 7th 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 3 p.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile insanity & a Cerebral Hemorrhage

18. WHERE WAS DISEASE CONTRACTED _____ (duration) yrs. mos. 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? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical (Signed) J.B. Bouty, M. D.

4/9 . 1930 (Address) Chilhowee 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 Shilow cemetery DATE OF BURIAL Apr 9 30

20. UNDERTAKER Sweeney-Cook ADDRESS Chilhowee

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.

MAY 26 1930

