

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791  
1003**

Primary Registration District No. **2915**

File No. **14959**  
Registered No. **4422**  
St. .... Ward

**2. FULL NAME**

**James Anderson**

(a) Residence No. **2915 Lucas** St., **21** 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 **male**  
4. COLOR OR RACE **Col**  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 1, 1904**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
**25 5 25**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Janitor 11<sup>1/2</sup>**  
(b) General nature of industry, business, or establishment in which employed (or employer) **12<sup>1/2</sup>**  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Jackson Tenn.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Jesse Anderson**

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

12. MAIDEN NAME OF MOTHER **Mary Holt**

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

14. INFORMANT **Walter Anderson**  
(Address) **2915 Lucas**

15. FILED: 19 **May 1930**  
REGISTRAR **Max C. ...**

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/26 1930**

17. I HEREBY CERTIFY, That I attended deceased from **4-22-1930** to **4-26-1930** that I last saw h. **11<sup>15</sup> A. m.** alive on **4-26-1930**, and that death occurred, on the date stated above, at **11<sup>15</sup> A. m.**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Acute perforating Gastric Ulcers  
Peritonitis  
Hemolytic streptococcus Septicemia**

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **11/10/1**  
(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? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **Bacteriology + autopsy**  
(Signed) **W. H. ...** M. D.

**4/26/1930** (Address) **Barnes Hospital**

\*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 **Washington Park** DATE OF BURIAL **5-4-1930**

20. UNDERTAKER **R. M. C. Green** ADDRESS **3517 Saelede Ave**

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.

22

72

7