MAY 27 1930

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

Do not use this space.

17011

1. PLACE OF DEATH
County Platte
Township Weston
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 698
Primary Registration District No. 5926

File No. .....
Registered No. .....

2. FULL NAME Unnamed James O Anderson (Father)

(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 Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 30 30

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Weston
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER James Odie Anderson

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

12. MAIDEN NAME OF MOTHER Lillian Bramble

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

14. INFORMANT Dr L C Calvert
(Address) Weston Mo

15. FILED 5/5, 1930 J H Bruce
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Apr 30, 1930 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature birth

159

16 (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? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) L C Calvert, M. D
, 19 (Address) Weston 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 Disposed of by family on farm.

DATE OF BURIAL May 1 1930

20. UNDERTAKER no undertaker

ADDRESS