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

Do not use this space.

17800

File No. 791

Registered No. 4908

1. PLACE OF DEATH

County ..... Registration District No. 1003

Township ..... Primary Registration District No. .....

City St. Louis (No. Mo. Baptist Hospital St. ..... Ward)

2. FULL NAME Thomas L. Anderson

(a) Residence. No. Sullivan, Mo. St., 12 Ward. Sullivan Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 10. 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	7.	9	

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) Franklin County
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Frank Anderson

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

12. MAIDEN NAME OF MOTHER Sarah Johnson

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

14. INFORMANT Wm. C. Anderson
(Address) Sullivan Mo

15. FILED OCT 19 1930 Mary C. Harlen, REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-19- 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-6- 1930, to 5-19- 1930, that I last saw him alive on 5-19- 1930, and that death occurred, on the date stated above, at 5:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pneumonia Hypostatic Lobar

34

108 (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) C.H.S. Epilepsy

(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? Feeling

(Signed) R. E. Anderson, M. D

5/19-, 1930 (Address) Wall Bldg

*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 Chapel Hill Cem. Sullivan, Mo. DATE OF BURIAL May 21 1930

20. UNDERTAKER Guedmeyer ADDRESS 3934 N. 20

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.