

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

Do not use this space.

23891

1. PLACE OF DEATH

County Platte
Township Edgerton
City Edgerton (No.)

Registration District No. 693
Primary Registration District No. 4413

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)
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.
(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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-2-1957

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 8 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Surveyor
(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) Platte Co MO

10. NAME OF FATHER Asa H. Anderson

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

12. MAIDEN NAME OF MOTHER Mary Roberts

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

14. INFORMANT Mrs. Albert Foster
(Address) Edgerton MO

15. FILED 8/10, 1930 H. H. Rollins REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July-21 19 30

17. I HEREBY CERTIFY, That I attended deceased from July 12 19 30 to July 20 19 30 that I last saw him alive on July 30 19 30 and that death occurred, on the date stated above, at 19:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

137
132B
malumia
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Abc Shady Jr M. D.

, 19 (Address) Edgerton 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 DATE OF BURIAL

Anderson Park July-23-1930

20. UNDERTAKER ADDRESS

H. H. Rollins Edgerton

N. B.—Be careful! Carefully supplied. AGE, SEX, and OCCUPATION should state CAUSE OF DEATH in the forms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 6 1930

SECRET

[illegible]

**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 Platte

Registration District No. 693

File No.

Township Edgerton

Primary Registration District No. 4415

Registered No.

City Edgerton (No.)

St. Ward

2. FULL NAME

Galen B. 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

M

4. COLOR OR RACE

W

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

M

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 8/10/1930

W. H. Rollins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21 19 30

17.

I HEREBY CERTIFY That I attended deceased from, 19....

that I last saw him alive on, 19...., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
the pulmonary of Prostate
gland (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) W. H. Rollins, 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

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be stated EXACTLY as furnished, and state CAUSE OF DEATH as given by attending physician, and that it may be properly classified. REGISTRARS SHALL NOT REJECT OR REFUSE FOR CERTIFICATES UNTIL THEY ARE AS PRESCRIBED BY LAW

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