

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

Do not use this space.

29819

File No. \_\_\_\_\_  
Registered No. **3615**  
St. \_\_\_\_\_ Ward)

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Acacia Primary Registration District No. \_\_\_\_\_  
City Camden (No. R.C. General Hosp) St. \_\_\_\_\_ Ward)

**2. FULL NAME**

James Anderson  
(a) Residence No. 1656 Jefferson St Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 2 1868

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>62</u>	<u>7</u>	<u>29</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Taxi driver  
(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) Kentucky

10. NAME OF FATHER Lee Anderson

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Reverend Clerk  
(Address) R.C. General Hosp.

15. FILED 9/3 1930 M. M. Crome  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-1 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-25 1930 to 9-1 1930 that I last saw him alive on 9-1 1930 and that death occurred, on the date stated above, at 10:30 a.m.

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

Cerebral Thrombosis  
935  
930

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) P. E. Williams M. D.  
9-1 1930 (Address) Subst R.C. Gen. Hosp

\*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

Maple Hill 9/3 1930

20. UNDERTAKER ADDRESS

R. V. Lindsey's one KMo

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.

