

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

Do not use this space.

34586

4205

1. PLACE OF DEATH **JACKSON**
 County..... Registration District No. **399**
 Township **Kaw** Primary Registration District No. **1002**
 City **Kansas City, Mo.** (No. **3414 Genesee**) St. _____ Ward _____

2. FULL NAME **Dugald F. Anderson**
 (a) Residence. No. **3414 Genesee** St. **5** Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred **18** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 **Effie Anderson**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan. 12, 1868**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 9 11

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Mail Handler**
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer **K.C. Terminal**

9. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.**
 (STATE OR COUNTRY)

10. NAME OF FATHER **James Anderson**

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

12. MAIDEN NAME OF MOTHER **Joan Ferguson**

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

14. INFORMANT **Mrs. Effie Anderson,**
 (Address) **3414 Genesee**

15. FILED **10/24 31** **M. M. Crome** REGISTRAR
asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 23, 1931** 19

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at **1:15 PM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

450
Carcinoma jaw.
Metastasis to chest.

(duration) yrs. **6** mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF _____?

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Pathological diagnosis**
 (Signed) **A. H. Ziegler**, M. D.

, 19 (Address) **818 Ohio St. 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 **Mt. Moriah Cemetery** DATE OF BURIAL **10-26-31** 19

20. UNDERTAKER **R.V. Lindsey & Sons, Inc.** ADDRESS **K.C. Mo.**

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.

Med. cut ready.