

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

Do not use this space.

26375

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City Mo.

Registration District No. 885
Primary Registration District No. 2002

File No. _____
Registered No. 3283 (Ward)

2. FULL NAME

Charles Frazier Anderson

(a) Residence No. 404 Gilie 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

col

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

Single

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

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

June 11th 1932

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

2

2

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

Child

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Kansas City Mo 1

10. NAME OF FATHER

Wm Anderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Okla

12. MAIDEN NAME OF MOTHER

Maria Foster

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Okla

14.

INFORMANT

(Address)

Maria Anderson
404 Gilie

15.

FILED

8/29/32
m. m. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug 13th 1932

17.

I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractures
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

158
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) _____, M. D.

, 19____ (Address) Deput Caron

*State the DISEASE CAUSING DEATH, or in depths 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

Licks Mo

Aug 30 1932

20. UNDERTAKER

ADDRESS

West Appleton + Jones

1600 E 19th

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.



1875