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

Do not use this space.

13841

File No. .....

Registered No. 54

1. PLACE OF DEATH
County Livingston
Township Richhill
City ..... (No. ..... St. ..... Ward)

Registration District No. 508
Primary Registration District No. 5685

2. FULL NAME Robert A. 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 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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: Carolyne Anderson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 2-1874

7. AGE: Years 58 | Months 8 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

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): 0
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Holt County
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER: William H. Anderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
(STATE OR COUNTRY) New York
12. MAIDEN NAME OF MOTHER: Melinda Colwell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Maitland
(STATE OR COUNTRY) Missouri

14. INFORMANT: Mrs Carolyne Anderson
(Address) Chillicothe Missouri

15. FILED 4/20, 1933 R. Barney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 20 1933

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1933, to April 20, 1933, that I last saw him alive on April 18, 1933, and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tbc.
Pt. 23 (duration) 5 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? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) K. J. Brennan, M. D.
4/20 1933 (Address) Chillicothe 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: Wheeling Mo | DATE OF BURIAL: April 21 1933

20. UNDERTAKER: Frank C. Bailey | ADDRESS: Wheeling 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 important.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD