

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

Do not use this space.

**1. PLACE OF DEATH**

County Lelark  
Township Grant  
City Revere (No. \_\_\_\_\_)

Registration District No. 192  
Primary Registration District No. 5268

File No. 522  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Bertha Rose Anderson

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 28-1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
21

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Lelark Co, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Perry A. Anderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lee Co, Iowa  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Gladys Calvert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lelark Co, Mo  
(STATE OR COUNTRY)

14. INFORMANT Perry August Anderson  
(Address) Revere, Mo

15. FILED Jan 19 1934 J. L. McConnell  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1934 to Jan 18 1934 that I last saw him alive on Jan 17 1934 and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Lobar Pneumonia

108 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 108 (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) J. L. McConnell, M. D.

. 19 (Address) Revere 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 REINTERMENT DATE OF BURIAL

Peasville Mo Jan 19 1934

20. UNDERTAKER ADDRESS J. M. Epperhart Revere, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FEB 2 1934

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