

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

Do not use this space.
32538

OCT 15 1934

1. PLACE OF DEATH

County Greene Registration District No. 318
Township 162 N. National Primary Registration District No. 2001 File No. 468
City Springfield St. _____ Ward _____

2. FULL NAME

August C. Anderson
(a) Residence, No. 762 N. National 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marie Anderson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 23 1903
7. AGE YEARS 31 MONTHS 7 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Unknown
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield

13. NAME August Anderson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

15. MAIDEN NAME Anna Lindberg

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT (ADDRESS) The City Manager
762 N. National

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellevue DATE 9/27/34

19. UNDERTAKER (ADDRESS) Wm. H. Hines
Springfield

20. FILED 9-27 1934

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 15 at 34, to Sept 25 at 34
Last saw him alive on Sept 25 at 34. Death is said to have occurred on the date stated above, at 4:15 p.m.
The principal cause of death and related causes of importance were as follows:

Endocarditis, acute
39
91A
Other contributory causes of importance:
Arteriosclerosis, chronic
probably cardiac

Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Robert Williams, M. D.
(Address) Springfield Mo

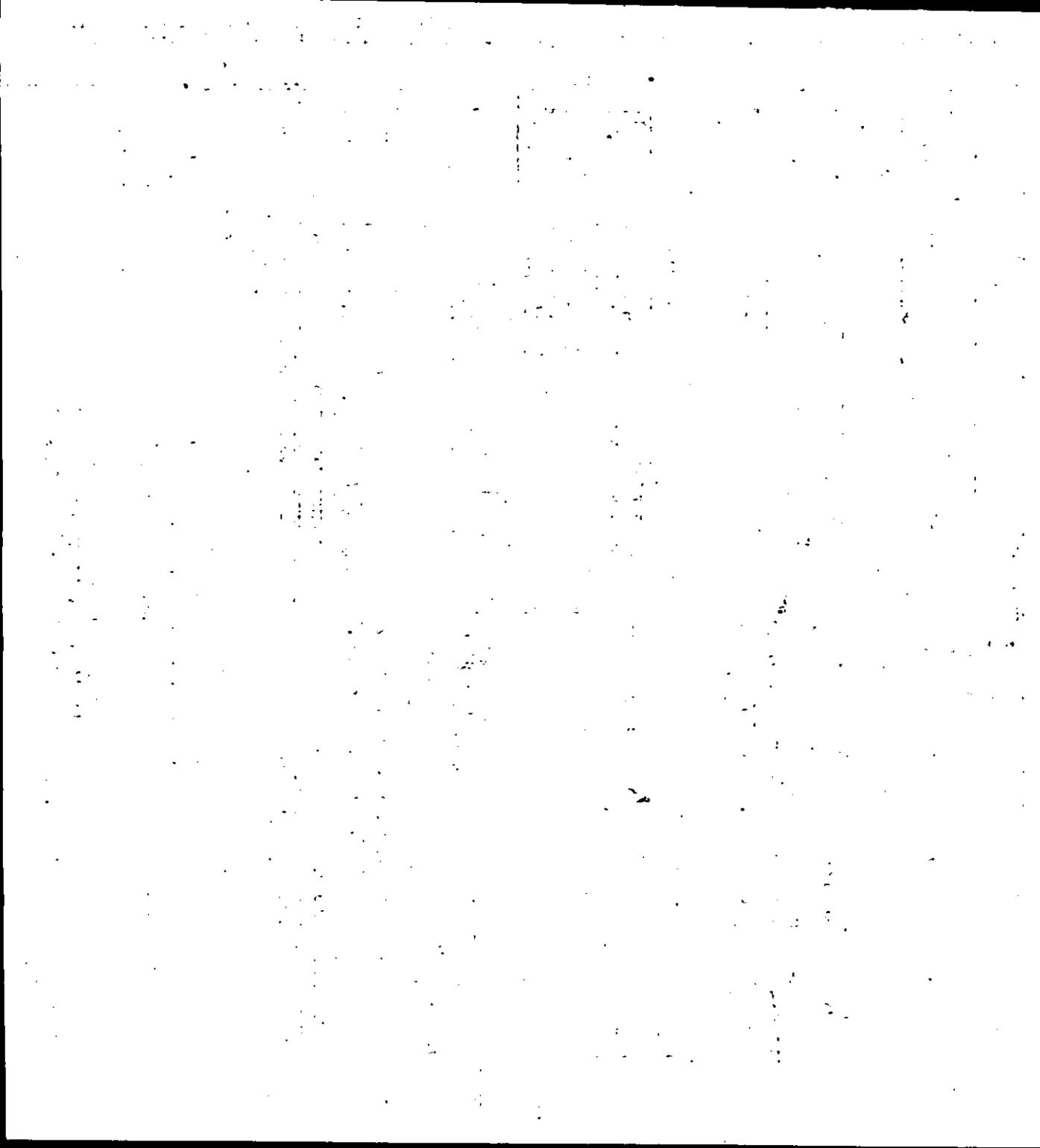
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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OCCUPATION

MOTHER FATHER

Date of onset
Aug
1-1934



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield (No.)

File No.

Registered No. 468

St. Wardy

2. FULL NAME

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 31 7 2

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER MOTHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED

[Signature]
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25, 1934

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Cardiopulmonary acute
asthma chronic
probably specific infection
Lung

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) R. F. Williams, M. D.

(Address) Springfield mo

SUPPLEMENTARY

34

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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