

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

Do not use this space.

JAN 8 1935

1. PLACE OF DEATH

County Dunklin
Township Buffalo
City (No. _____) _____

Registration District No. 283
Primary Registration District No. 5402

File No. 39006
Registered No. _____
St. _____ Ward _____

2. FULL NAME Baby Florence Isabelle Anderson

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/2/34

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Baby
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Baby
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) MO

FATHER 13. NAME Harry Washington Anderson

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

MOTHER 15. MAIDEN NAME Louis Ladi Cameron

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

17. INFORMANT (ADDRESS) Hather

18. BURIAL, CREMATION, OR REMOVAL PLACE Cockrum Cemetery DATE 11-7 1934

19. UNDERTAKER Emerson T. Burns (ADDRESS) Cardwell, Arkansas

20. FILED 12-15 1934 - E. S. Newson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-6 1934

22. I, HEREBY CERTIFY, That I attended deceased from 11/6/34, 1934, to 11/6/34, 1934.

I last saw her alive on 11/6/34, 1934. Death is said to have occurred on the date stated above, at 2:30 p. m.

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

Cerebral hemorrhage Date of onset 11/3/34

Other contributory causes of importance:

Bells palsy 82 D

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

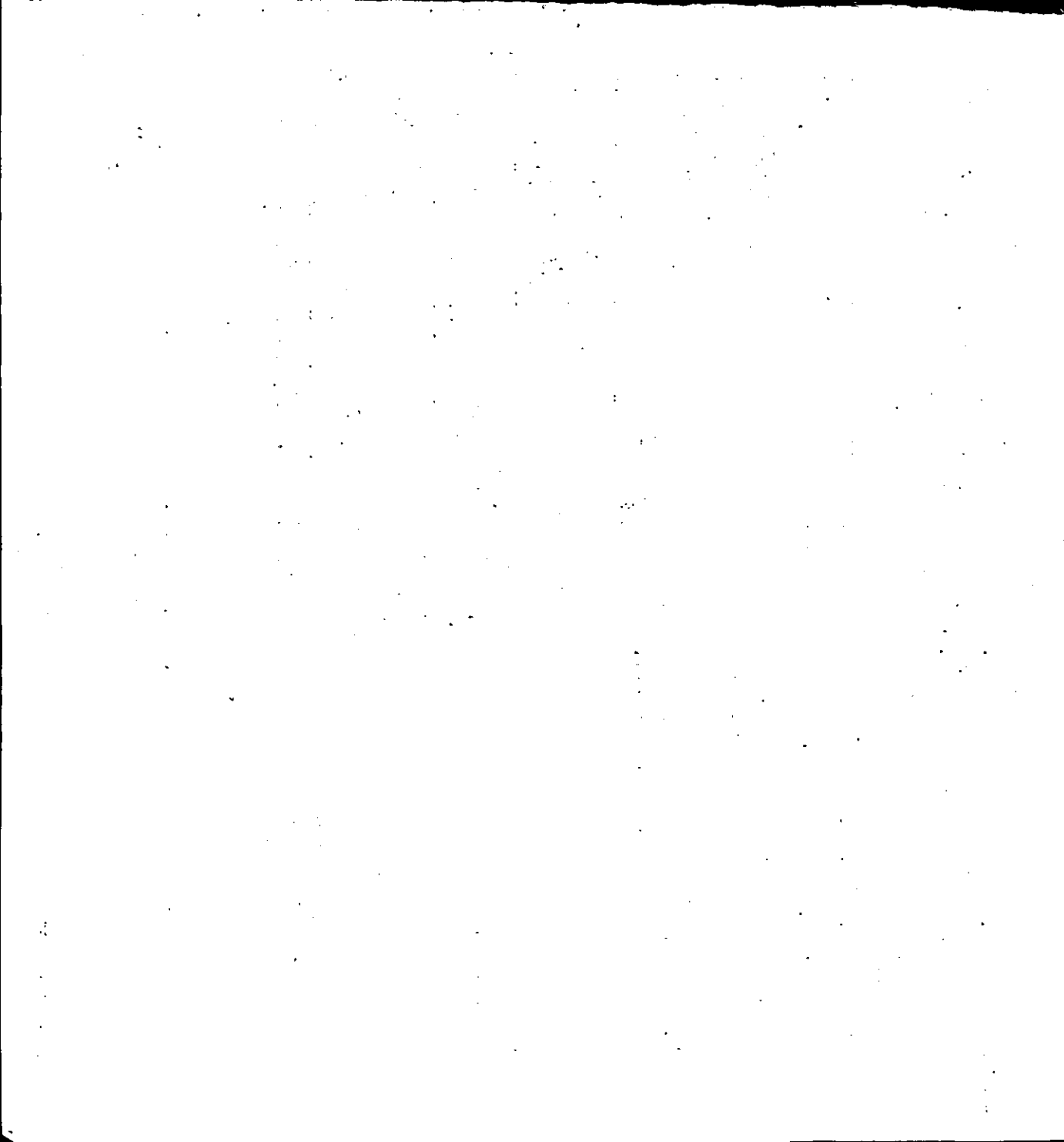
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1934

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? No
If so, specify _____

(Signed) Wallace D. English, M. D.
(Address) Cardwell, MO.



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dunklin

Registration District No. 283

Township

Primary Registration District No. 5402

City Fluckey

(No.)

File No.

Registered No.

St. Ward

2. FULL NAME

(a) Residence, No. Fluckey

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

F

4. COLOR OR RACE

W

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

S

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

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

7. AGE

YEARS 0

MONTHS 0

DAYS 4

If LESS than 1 day, hrs. or min.

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

4-10-1933

R. M. Wason

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11 7 6 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:

Cerebral hemorrhage Date of onset

Birth Injury

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)....., M. D.

(Address).....

SUPPLEMENTARY

160 b

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

JAN 28 1935

S-39006

Birth injury