

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.

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

Do not use this space.

NOV 9 1935

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis Mo.* (No. *5563*, *Enright Ave*) File No. **34210**
 St. _____ Registered No. **8633**
 Ward _____

2. FULL NAME

John Anderson
 (a) Residence, No. *5563 Enright Ave* St., *5* Ward. (If nonresident, give city or town and State)
 (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.

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 *Ella Anderson.*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct. 7. 1869.*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66. 0. 6.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Oil.*
 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) *Denmark.*

MOTHER FATHER
 13. NAME *Andreas Anderson.*

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

15. MAIDEN NAME *Unknown*

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

17. INFORMANT *Ella Anderson*
 (ADDRESS) *5563 Enright Ave*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Laurie Hill* DATE *Oct. 16, 1935*

19. UNDERTAKER *Edith E. Ambruster*
 (ADDRESS) *4234 Manchester Ave*

20. FILED *14 1935* 19 _____
J. Brebeck
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 13, 1935*

22. I HEREBY CERTIFY, That I attended deceased from *Aug. 15, 1935* to *Sept. 1, 1935*
 I last saw him alive on *Sept. 1, 1935*. Death is said to have occurred on the date stated above, at *8:30 P. m.*
 The principal cause of death and related causes of importance were as follows:

*Angina pectoris
 Myocarditis Chronic
 Arterio-sclerosis*

Other contributory causes of importance: *940*

Name of operation _____ Date of _____
 What test confirmed diagnosis? *E.C. 9* Was there an autopsy? *no*

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? *no*
 If so, specify _____

(Signed) *H. G. Newman*, M. D.
 (Address) *3720 Washington Ave*

