

REC'D APR 22 1938

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

Do not use this space.

11693

## 1. PLACE OF DEATH

County Pemisscat  
Township Broggadia  
City Broggadia (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 653  
Primary Registration District No. 5871

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

## 2. FULL NAME

Theo Dasia Anderson 536

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ 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 M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) inf

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-24-36

7. AGE YEARS 1 MONTHS 2 DAYS 9 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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) Broggadia, Miss

13. NAME L. S. Anderson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Copal Co, Miss

15. MAIDEN NAME Beatrice Caldwell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Copal Co, Miss

17. INFORMANT L. S. Anderson (ADDRESS) Broggadia, Miss

18. BURIAL, CREMATION, OR REMOVAL PLACE Holly Shaul DATE 11-3 1937

19. UNDERTAKER Superior Undert Co (ADDRESS) Stark, Miss

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Registrar. 586

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-3-1937

22. I HEREBY CERTIFY, That I attended deceased from 11/3- 1937, to 11/3- 1937

I last saw him alive on 11/3-1937 Death is said to have occurred on the date stated above, at 6 P.M.

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

Broncho pneumonia Date of onset 11/3-37

Other contributory causes of importance:

Whooping Cough 3 wks

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? None 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?

If so, specify \_\_\_\_\_

(Signed) L. D. Denton, M. D.

(Address) Broggadia, Miss

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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

11693  
Do not use this space.

1. PLACE OF DEATH

(a) County Plumont Registration District No. 65-3  
(b) Township Braggadocia Primary Registration District No. 3871  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Theodora anderson

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) mf

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-3, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from 11-3, 1937 to 11-3, 1937

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-24-1936

I last saw her alive on 11-3, 1937. Death is said to have occurred on the date stated above, at 6 P.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 2 9

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Bronchitis Pneumonia  
Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Braggadocia, Mo.

Other contributory causes of importance:

13. NAME L. Z. anderson

Whooping Cough

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Capital, Mo.

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

15. MAIDEN NAME Beatrice Caldwell

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

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Capital, Mo.

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS) L. Z. Anderson  
Braggadocia

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Holly Grove DATE 11-3, 1937

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

19. FUNERAL DIRECTOR (ADDRESS) German Indt Co  
Steele, Mo.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

20. FILED 7-14, 1938 J. W. Rhodes  
Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) L. D. Denton, M. D.  
(Address) Braggadocia, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH shall be properly classified. Exact statement of OCCUPATION, if important, should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION, if important, should be stated EXACTLY.

