

REC'D NOV 21 1938

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

38

34518

Do not use this space.

3854

1. PLACE OF DEATH
(a) County Jackson Registration District No. 395
(b) Township Kear Primary Registration District No. 1002
(c) City K.C. Mo. (d) Street No. General Hospital #2 St. 2
(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 531/2 Elijah Anderson
(a) Residence, No. 1108 1/2 Independence 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

3. SEX male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Don't know
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1945
7. AGE YEARS MONTHS DAYS If LESS than 1 day hrs. or min.
93
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Don't know
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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
13. NAME Don't know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
15. MAIDEN NAME Don't know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
17. INFORMANT (ADDRESS) Record Clerk General Hosp #2
18. BURIAL, CREMATION, OR REMOVAL PLACE Records Building DATE Nov 4 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) St. Joseph's Hospital
20. FILED Nov 4 1938 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-30 1938
22. I HEREBY CERTIFY, That I attended deceased from 9-21 1938 to 9-30 1938
I last saw him alive on 9-30 1938 Death is said to have occurred on the date stated above, at 11:42 P.M.
The principal cause of death and related causes of importance were as follows:
Premia
Senile Dementia
n.m.o.
Date of onset
- Other contributory causes of importance: 12:15
- 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) G. O. Turner M. D.
(Address) General Hospital #2

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

_____ or by _____
Registered Apprentice No. _____, working under my personal supervision.

Signed *P. J. West*

Licensed Embalmer No. *2710*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.