

NOV 14 1938

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

36430
Do not use this space.

1. PLACE OF DEATH
(a) County Demiseat Registration District No. 651
(b) Township Caruthersville Primary Registration District No. 4388 Registered No. 101
(c) City Caruthersville (d) Street No. _____
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Harold Leroy Anderson
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 24, 1938
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 2 9
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 ✓ 1

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

FATHER 13. NAME C. J. Anderson

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

MOTHER 15. MAIDEN NAME Vernice Lemaw

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

17. INFORMANT (ADDRESS) C. J. Anderson Caruthersville, Mo

18. BURIAL, CREMATION OR REMOVAL PLACE Caruthersville, Mo DATE 10/3/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Star as per Co Caruthersville, Mo

20. FILED Oct 31, 1938 Aida Martin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 3, 1938
22. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1938 to Oct 3, 1938.
I last saw him alive on Oct 3, 1938 Death is said to have occurred on the date stated above, at 11 A. m.
The principal cause of death and related causes of importance were as follows:
mal nutrition ✓ Date of onset _____

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? No
If so, specify Fred. L. Ogilvie, M. D.
(Signed) Fred. L. Ogilvie, M. D.
(Address) Caruthersville, 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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STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

THIS CERTIFICATE IS TO BE FILLED OUT BY THE LICENSED EMBALMER AT THE PLACE OF INTERMENT.

NAME OF DECEASED: _____
DATE OF DEATH: _____
PLACE OF INTERMENT: _____

CAUSE OF DEATH: _____
MANNER OF DEATH: _____
LOCALITY OF DEATH: _____
CITY: _____ STATE: _____
COUNTY: _____
AGE: _____ SEX: _____
RACE: _____
RELIGION: _____
EDUCATION: _____
OCCUPATION: _____
MARRIED: _____
SINGLE: _____
WIDOWED: _____
DIVORCED: _____
MILITARY SERVICE: _____
REMARKS: _____

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, Not Embalmed, or by _____

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

Signed _____

Licensed Embalmer No. _____

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH
(a) County Pemiscot Registration District No. 651
(b) Township _____ Primary Registration District No. 4388 Registered No. _____
(c) City Caruthersville (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 Harold Le Roy 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 M 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 MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 2 9

OCCUPATION
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 _____

FATHER
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19
19. FUNERAL DIRECTOR (ADDRESS) _____
20. FILED _____, 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 3 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him _____ 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:
Malnutrition

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 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) Fred L. Ogilvie, M. D.
(Address) Caruthersville Mo

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

