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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REC'D FEB 23 1939

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

2228
Do not use this space.

1. PLACE OF DEATH
(a) County Franklin Registration District No. 294
(b) Township Central Primary Registration District No. 5409B Registered No.
or
(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. 18 mos. ~~ds.~~ (f) How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

2. PRINT FULL NAME 536 William Harold Andereck.
(a) Residence, No. Robertsville. R.R #1. St. ✓
(Usual place of abode, if no street address, write county or city) (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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Andereck.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 1, 1854
7. AGE YEARS 84 MONTHS 3 DAYS 28 If LESS than 1 day, ...hrs. or ....min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co Ill.

FATHER
13. NAME William Andereck.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co Ill.

MOTHER
15. MAIDEN NAME H. Ross.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co. Ill.

17. INFORMANT (ADDRESS) Aileen Miller. Robertsville. R.R #1.
18. BURIAL, CREMATION, OR REMOVAL PLACE Fairview Cemetery DATE Feb 1 1939
19. FUNERAL DIRECTOR (NAME) Sherwood Kitchell (ADDRESS) St. Clair Mo.
20. FILED ....., 19.... W. H. Dwyer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 29. 1939
22. I HEREBY CERTIFY That I attended deceased from Jan. 29 1939 to Jan. 29 1939
I last saw him alive on Jan. 29 1939 Death is said to have occurred on the date stated above, at 3:30 a.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy. Date of onset Jan. 29, 1939.

Other contributory causes of importance:
Arteriosclerosis.

Name of operation none Date of ✓
What test confirmed diagnosis? Clinical 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
(Signed) W. E. Kitchell, M. D.
(Address) St. Clair.

(Licensed Embalmer's Statement on Reverse Side)

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 Sherwood Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair, Mo

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

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