

REC'D APR 19 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

11583

Do not use this space.

1. PLACE OF DEATH

(a) County Miller
 (b) Township Clair
 (c) City Katter

Registration District No. 565Primary Registration District No. 5761aRegistered No. 14

(d) Street No. _____
 (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

Levi Anderson
 (a) Residence, No. _____ 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 <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lucy Anderson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 28-1857</u>		
7. AGE YEARS <u>82</u>	MONTHS <u>0</u>	DAYS <u>24</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>		
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) <u>Syracuse</u>		
13. NAME <u>Anderson</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>		
15. MAIDEN NAME <u>Mary</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>		
17. INFORMANT (ADDRESS) <u>Mrs Arthur Russell Osage Beach Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>New Hope Cem</u> DATE <u>2-24</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Buried by Friends</u>		
20. FILED <u>2-23</u> 19 <u>39</u> <u>CR Hawkins</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-22 1939

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 11:45 P.M.

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

Died without any Medical Attention whatsoever

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? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

RECEIVED

Miller County Health Dep't.

County File Number 29-58

Date Filed 4-12-39

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

11583

Do not use this space.

1. PLACE OF DEATH

(a) County Miller

Registration District No. 365-

(b) Township Blaine

Primary Registration District No. 3761A

Registered No. 14

(c) City

(d) Street No. (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 Levi Anderson

(a) Residence, No. 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

m

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

m

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.

82

0

24

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

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

FATHER 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. FUNERAL DIRECTOR
(ADDRESS)

20. FILED 2-23-39 C. R. Hawkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-22 1939

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:

Died without medical attention

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?

If so, specify

(Signed) No Physician called M. D.

(Address) C. R. Hawkins Reg.

Brownlee
Mo.

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

EX-11-1000