DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 15 1940

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 12913

Registrar's No. 3115

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1419-21 Franklin Avenue. 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3947 Botanical
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Truman F. Anderson 531

3. (b) If veteran, name war None

3. (c) Social Security No. 490-09-5781

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Juanita Anderson

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased april 14 (Month) 1915 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
24	11	19	hr. min.

9. Birthplace Newman Grove (City, town, or county) Nebraska (State or foreign country)

10. Usual occupation clerk

11. Industry or business Missouri Auto Supply Co. 10

FATHER
12. Name Fred. A. Anderson 10
13. Birthplace Newman Grove (City, town, or county) Nebraska (State or foreign country)

MOTHER
14. Maiden name Annie Nordgren
15. Birthplace Newman Grove (City, town, or county) Nebraska (State or foreign country)

16. (a) Informant's own signature Juanita Anderson

(b) Address 3947 Botanical

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-4-194 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Vet

18. (a) Signature of funeral director Thos J Finan

(b) Address 1519 S. Grand Blvd.

19. (a) APR 4 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 3 year 1940 hour 11 minute 00 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Suffocation	
Due to Generalized Burns	
Due to Suffered during fire in Building at 1419 Franklin	
Other conditions Abst 11:00 p.m. April 3-1940 When deceased was trapped in Basement of	
Major findings: Extensive Damage to Stock $2500.00 Damage to Contents $2500.00	
Of autopsy Accident	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 4/3/1940

(c) Where did injury occur? St Louis Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Industrial Place (Specify type of place)

While at work? Yes Kind of injury Fire

23. Signature Albert Sperry (M.D. or other)

Address Alderson Broaddus Date signed 4-4-40

(Licensed Embalmer's Statement on Reverse Side)

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.

JUN 18 1954

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 Thomas J Fuller

Licensed Embalmer No. 1197

P. O. Address St Louis Mo

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

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