

Registration District No. 253

Primary Registration District No. 4153

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Davies
(b) City or town Lock Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME John Riley Anderson 536

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Melvina Anderson 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased May 31, 1857
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>10</u>	<u>29</u>	hr. _____ min. _____

9. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Wabash R. R.

11. Industry or business _____

MOTHER FATHER
12. Name Samuel Anderson
13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Wise
15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Melvina Anderson
(b) Address Lock Springs, Mo.

17. (a) Burial (b) Date thereof 5-2-'40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cem.

18. (a) Signature of funeral director E. B. Norman

(b) Address Chillicothe, Mo.

19. (a) A. Y. ... (b) A. Y. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) Lock Springs (b) County Davies
(c) City or town Lock Springs, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? April 30 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1940 hour _____ minute 100 M.

21. I hereby certify that I attended the deceased from April 20, 1940, to April 30, 1940
that I last saw him alive on April 20 and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage
Duration _____

Due to _____
Due to 42 in

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 230

(Specify type of place) _____
While at work? (e) Means of injury _____

23. Signature A. Y. ... (M. D. or other) _____

Address Lock Springs Date 5/2/40

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.

RECEIVED

District Health Officer No. 117

District File Number 540-791

Date Filed MAY 18 1948

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.....

..... Elton F. Norman & E. R. Norman (2374)....., Registered Apprentice No.....
working under my personal supervision.

Signed *ER Norman*.....

Licensed Embalmer No..... 4036.....

P. O. Address Chillicothe, Mo.

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.