

FILED MAY 17 1940

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

15411

Do not use this space.

## 1. PLACE OF DEATH

- (a) County Livingston Registration District No. 2-14  
 (b) Township North Primary Registration District No. 2-683  
 (c) City Adlow (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (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

- 531a Minnie May Anderson  
 (a) Residence, No. LIVINGSTON CO. RURAL St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 17 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
72 4 16

- 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. Invalid  
 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) California

- FATHER 13. NAME Edija Anderson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennesse

- MOTHER 15. MAIDEN NAME Blair  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) About Knoxville

17. INFORMANT (ADDRESS) Mrs Chas Anderson  
Adlow Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE McKrossie DATE 4-4-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. G. Dickerson  
Bogard Mo

20. FILED 4-4-40 1940 Leiter G. Leving  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 3, 1940

22. I HEREBY CERTIFY, That I attended deceased from April 2, 1940, to April 2, 1940  
 I last saw her alive on April 2, 1940 Death is said to have occurred on the date stated above, at 11:30 A.M.  
 The principal cause of death and related causes of importance were as follows:

Date of onset

Stasis pneumonia 2/11/40

Other contributory causes of importance:

Senility, Gen mental Degeneray

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 \_\_\_\_\_

(Signed) W. J. Mares, M. D.936 (Address) Adlow Mo

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RECEIVED  
District Health Officer No. 117  
District File Number 540-284  
Date Filed MAY 15 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 .....

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

Signed *E. A. Decker*

Licensed Embalmer No. *2534*

P. O. Address *Bayard MD*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-411

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 514

Primary Registration District No. 5683

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Lumpkin

(b) City or town Lawrence, T. P.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

3. (a) PRINT FULL NAME Missie May Anderson

(b) If veteran, name war \_\_\_\_\_

3. Social Security No. \_\_\_\_\_

20. DATE OF DEATH: month Apr day 5 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex 7 5. Color or race W

6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

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

Immediate cause of death: Stasis pneumonia

8. AGE: Years 72 Months 7 Days 16 If less than one day \_\_\_\_\_ min.

Due to Robert

Due to \_\_\_\_\_

9. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) Senility sen mental

10. Usual occupation \_\_\_\_\_

Major findings: Degeneracy

11. Industry or business \_\_\_\_\_

Of operations \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) \_\_\_\_\_ (Registrar's signature)

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Geo Morse (M. D. or other) \_\_\_\_\_

Address Ludlow Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

