DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

19264

State File No. [illegible]

Registration District No. 684 — Primary Registration District No. 5912 — Registrar's No. [illegible] 28

1. PLACE OF DEATH:
(a) County Pike County Farm
(b) ~~City or town~~ (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 2 (Specify whether years, months or days)
In this community 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike
(c) City or town Rural (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 Harry Pell Anderson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willie A. Anderson
6. (c) Age of husband or wife if alive 46 yrs
7. Birth date of deceased June 25 (Month) 1868 (Day) (Year)

8. AGE: Years 71 72 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Ills (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Michel Anderson
13. Birthplace Ills (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Meacham
15. Birthplace Ills (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Anderson
(b) Address St Louis Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation St Louis Mo

18. (a) Signature of funeral director W S Mates
(b) Address Vandalia Mo

19. (a) 5-7 10-1940 (Date received local registrar) (b) M. Bummerkamp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29 year 1940 hour 11 minute 45 P M.

21. I hereby certify that I attended the deceased from June 5 to June 5, 1939 to 4/29, 1940; that I last saw him alive on 7/39, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uraemic poison	
Due to Chronic Glomerulo Nephritis	
Due to Arteriosclerosis,	12
Other conditions Cystitis, Senility (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr J P Dougherty (M. D. or other) Dr
Address Vandalia, Mo Date signed 4/30/40

(Licensed Embalmer's Statement on Reverse Side)

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

Rev. 5-1-39
1 x 19311

RECEIVED
District Health Officer No. 10
District File Number 6-40-1126
Date Filed JUN 7 1940

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 W B Wales

Licensed Embalmer No. 3325

P. O. Address Donaldson Ga

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.

S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19264

Registration District No. 684

Primary Registration District No. 3912

Registrar's No.

ROWENA MORE

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

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Cuivre 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 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. 4
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Harry Dell Anderson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased June 25 1868
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 4 If less than one day hr. min.

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

10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 5-10-1949 (Date received local registrar) (b) W. E. Summerlin (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 29
year 1949 hour minute 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	
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. R. Daugherty (M. D. or other)
Address Vandalia Mo Date signed

S-19264