

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21895

Registration District No. 386

Primary Registration District No. 553P

State File No.

Registrar's No.

1. PLACE OF DEATH: *Howell*

(a) County *Howell*

(b) City or town *Rural, Benton*

(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 *531*

3. (a) PRINT FULL NAME *Edward P. Anderson*

3. (b) If veteran, name war *24*

3. (c) Social Security No.

4. Sex *Male*

5. Color or race *W*

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

6. (b) Name of husband or wife *John Jane*

6. (c) Age of husband or wife if alive *52* years

7. Birth date of deceased *Oct 1863*

(Month) (Day) (Year)

8. AGE: *76* Years Months *8* Days *10*

If less than one day hr. min.

9. Birthplace *Ill.*

(City, town, or county) (State or foreign country)

10. Usual occupation *Farmer*

11. Industry or business

MOTHER FATHER

12. Name *John Anderson*

13. Birthplace *Ill.*

(City, town, or county) (State or foreign country)

14. Maiden name *Mary*

15. Birthplace *Indiana*

(City, town, or county) (State or foreign country)

16. (a) Informant's own signature *M. Mitchell*

(b) Address *Hocoma, Mo*

17. (a) *Burial* (b) Date thereof *6-18-40*

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Nautilus Ridge*

18. (a) Signature of funeral director *O. B. McElhine*

(b) Address *Mt. Home*

19. (a) *6-18-40* (b) *Vida W. SIMONS*

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo*

(b) County *Howell*

(c) City or town *Rural Benton*

(If outside city or town limits, write "RURAL")

(d) Street No. *Hocoma, Mo*

(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *17*

year *1940* hour *6* minute *0* M.

21. I hereby certify that I attended the deceased from *Jan 1*

19 *40* to *June 17*, 19 *40*

that I last saw him alive on *June 1*, 19 *40*

and that death occurred on the date and hour stated above.

Immediate cause of death *Myo Carditis*

9 enlarged Prostata

Due to *senility*

Due to *93A*

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?

344

(Specify type of place) (e) Means of injury

23. Signature *C. J. Beach* (M. D. or other)

Elijah J. Mc Date signed *6-18-40*

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.

RECEIVED

District Health Officer No. 5,

District File Number 740733

Date Filed 7/1/40

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.