

Registration District No. **400**

Primary Registration District No. **55530**

1. PLACE OF DEATH:

- (a) County **Jackson**
(b) City or town **Prairie View**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jackson County Home for the aged
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 mo.** (Specify whether

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Walter Anderson**

8. (b) If veteran, name war 8. (c) Social Security No. **None**

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **3**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Mar 21 1874**
(Month) (Day) (Year)

8. AGE: Years **64** Months **2** Days **23** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Laborer**

11. Industry or business **Unknown**

12. Name **Unknown**

13. Birthplace **Unknown** (City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **W. J. McCarthy**

(b) Address **Little Blue Mo**

17. (a) **General** (b) Date thereof **June 20-40**
(Burial, cremation, removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kirkville bet of 10 St**

18. (a) Signature of funeral director **H. G. ...**

(b) Address **Little Blue Mo**

19. (a) **7-2-40** (b) **W. J. McCarthy**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo** (b) County **Jackson**
(c) City or town **Little Blue**
(If outside city or town limits, write "RURAL")
(d) Street No. **J. C. Howell**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **14**
year **1940** hour **5** minute **59** M.

21. I hereby certify that I attended the deceased from **June 14** 19**40** to **June 14** 19**40** that I last saw him alive on **June 14** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis Chronica**

Due to _____
Due to **None**

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations _____
Of autopsy _____

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) (Means of injury)
23. Signature **W. J. McCarthy M.D.** (M. D. or other)
Address **Little Blue Mo** Date signed **June 14-40**

Duration **?**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WHILE FAMILIAR 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.

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.....

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.