

Registration District No. 470

Primary Registration District No. 3-633

Registrar's No. 125

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town St. Vernon
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Mo. State Sanatorium
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 94 days
 In this community 94 days
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
 (c) City or town Anderson (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3 year 1940 hour 10:25 minute _____ M.
 21. I hereby certify that I attended the deceased from July 1st 1940 to Oct 3 1940
 that I last saw him alive on Oct 3 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Lymphosarcoma Duration 1 yr.
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations Lymphosarcoma
 Of autopsy same

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

23. Signature Henry M. Miller (M. D. or other) _____
 Address St. Vernon Date signed _____

3. (a) PRINT FULL NAME KENNETH A. ANDERSON

3. (b) If veteran, name war No 3. (c) Social Security No. 513-05-5013

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ruth Anderson 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased August 31 1915
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 1 4 _____ hr. _____ min.

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

10. Usual occupation Electrician

11. Industry or business 1

12. Name George A. Anderson

13. Birthplace Anderson Mo
 (City, town, or county) (State or foreign country)

14. Maiden name Bertrude Torcum

15. Birthplace Marshall Illinois
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bertrude Anderson

(b) Address Anderson, Mo

17. (a) Removal (b) Date thereof 10-4-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson, Mo.

18. (a) Signature of funeral director M. W. Snow
 (b) Address Anderson, Mo.

19. (a) 10-3-1940 (b) P. A. HALMES
 (Date received local registrar) (Registrar's signature)

NOV 20 1940

205

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 M. D. Snow

Licensed Embalmer No. 4034

P. O. Address Andover, Me.

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.

Registration District No. **470**

Primary Registration District No. **3633**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **St. Vernon 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. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Kenneth A. 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 (Month) (Day) (Year)

8. AGE: Years **25** Months **1** Days **4** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER } 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **3**
year _____ hour _____ minute _____ M.

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 **Lympho Sarcoma**
Mediastinal in origin
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **47**
Of autopsy _____

Duration
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?

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

23. Signature **Chas. J. Freese** (M. D. or other) _____
Address **St. Vernon** Date signed **10/3**

SUPPLEMENTARY

