DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44033

Registration District No. 821 — Primary Registration District No. 4553 — Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston, Missouri (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 — In this community One Year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Sikeston (If outside city or town limits, write "RURAL")
(d) Street No. 518 E. Center St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mikie Lou Anderson
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 23 (Day) 1939 (Year)

8. AGE: Years 1 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Cardwell, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business None
MOTHER FATHER
12. Name John R. Anderson
13. Birthplace Wavely, Tenn. (City, town, or county) (State or foreign country)
14. Maiden name Opal Maxey
15. Birthplace Lilbourn, Missouri (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address Sikeston, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-40 (Month) (Day) (Year)
(c) Place: burial or cremation Cardwell, Missouri
18. (a) Signature of funeral director
(b) Address Sikeston, Missouri
19. (a) 1-8-1941 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1940 hour 10 minute — P. M.
21. I hereby certify that I attended the deceased from Dec 15, 1940 to Dec 16, 1940 that I last saw her alive on Dec 15, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Heart Failure	12-15-40
Due to: Mod Intoxication	1½ yrs
Due to:	0
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: NO	
Of autopsy: NO	

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) NO
(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? NO (Specify type of place)
While at work? (e) Means of injury

23. Signature M. L. Anderson (M. D. or other)
Address Sikeston Date signed 12-16-40

(Licensed Embalmer's Statement on Reverse Side)

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

158

RECEIVED
District Health Officer No. 2
District File Number 141-81
Date Filed 4/18/41

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. 774 working under my personal supervision.

Signed H J Wilson
Licensed Embalmer No. 774
P. O. Address Skowhegan Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44633

Registration District No. 821

Primary Registration District No. 4553

Registrar's No.

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Buffalo (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 years, months or days)

In this community

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 Mikie Lou Anderson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

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 1 | Months 4 | Days 22 | 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18

year 1940 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 Acute Heart Failure	
Due to Renal Malnutrition	
Due to Chronic Malaria	—
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 M. G. Anderson (M. D. or other)

Address Buffalo Mo. Date signed

SUPPLEMENTARY