

FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2759

Do not use this space.

1. PLACE OF DEATH

(a) County Howard
(b) Township Clinton
(c) City Glasgow
(e) Length of residence in city or town where death occurred yrs. mos. ds.Registration District No. 379Primary Registration District No. 4223Registered No. 41(d) Street No. 1

(If death occurred in Hospital or Institution, write its name instead of street and number) St.

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

LINDA ANDERSON(a) Residence, No. CLASGOW MO.

(Usual place of abode, if no street address, write county or city)

St. ☐

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Negro5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)Infant D5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Jan. 18, 1941

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.10

OCCUPATION

8. Trade, profession, or particular kind of
work done, as sawyer, bookkeeper, etc.9. Industry or business in which work
was done, as saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Glasgow Mo. D

13. NAME

Tom Anderson14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)St. Louis County Mo. D

15. MAIDEN NAME

Nellie Camp16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)St. Louis County Mo. D17. INFORMANT
(ADDRESS)Tom Anderson
Glasgow Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Glasgow Mo. DATE Jan 29, 194119. FUNERAL DIRECTOR (NAME)
(ADDRESS)Walker Anderson
Glasgow Mo.

20. FILED

1-28, 1941J. B. Anderson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Jan. 28, 1941

22. I HEREBY CERTIFY That I attended deceased from

1-18, 1941, to 1-28, 1941I last saw her alive on 1-28, 1941 Death is saidto have occurred on the date stated above, at 8:00 A.M.

The principal cause of death and related causes of importance were as follows:

Respiratory & Cardiac
Choke? 15H

Date of onset

2

Other contributory causes of importance:

Pneumonia

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

(Address)

J. B. Anderson
Glasgow Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 8
File Number
17-8-8

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.