DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39649

DEC 23 1941 825
Registration District No.

Primary Registration District No. 6 6 2 5

Registrar's No.

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

1. PLACE OF DEATH

(a) County Shannon
(b) City or town Birch, Moore Twp
(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: 101

(a) State (b) County 0
(c) City or town 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rose Adaline 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 Single 0

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

7. Birth date of deceased Feb (Month) 18 (Day) 1936 (Year)

8. AGE: Years 15 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Student
11. Industry or business

MOTHER FATHER
12. Name of Father Ralph Anderson
13. Birthplace (City, town, or county) Mo (State or foreign country)
14. Maiden name of Mother Mary Frances Hinnie
15. Birthplace (City, town, or county) Ill (State or foreign country)

16. (a) Informant Ralph Anderson
(b) Address Rat Mo

17. (a) Burial Burial, cremation, or removal (b) Date thereof 10-22-41 (Month) (Day) (Year)
(c) Place: burial or cremation Rat Mo

18. (a) Signature of funeral director none
(b) Address

19. (a) 10-22-41 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

744 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1941 hour 3 minute 23 A M.

21. I hereby certify that I attended the deceased from 10-21 1941, to 10-22 1941; that I last saw her alive on Oct 21 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
Due to Measles	
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 Frank Hyde (M. D. or other)
Address Ewing Mo Date signed 10-23-41

RECEIVED
District Health Officer No. 5,
District File Number 1241 2086
Date Filed _____

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 wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39649

Registration District No. 425 Primary Registration District No. 6085 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Rural (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 Mo (b) County Shannon
(c) City or town Rural Moore Twp (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rose A. 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 M

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

7. Birth date of deceased Feb. 18 (Month) (Day) 1926 (Year)

8. AGE: Years 15 | Months 8 | Days | 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) 10-22-41 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22. year 1941 hour noon minute M.

21. I hereby certify that I attended the deceased from ..., 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	
Due to	
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. D. or other)
Address Date signed

SUPPLEMENTARY