No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 30 1942

Registration District No. 918

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3783

Primary Registration District No. 6056

Registrar's No. 46

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

1. PLACE OF DEATH:
(a) County: Scotland
(b) City or town: ~~Memphis Mo~~ 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 ____ In this community: Three weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Schuyler
(c) City or town: DOWNING Mc Mo "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Tom A. Anders

3. (b) If veteran, name war: ____ 3. (c) Social Security No. ____

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

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

7. Birth date of deceased: Oct (Month) 10 (Day) 1873 (Year)

8. AGE: Years 68 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: Schuyler Co Mo. 0 (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: ____

FATHER
12. Name: Jacob Anders
13. Birthplace: Md. / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Nancy Adams
15. Birthplace: Md / (City, town, or county) (State or foreign country)

16. (a) Informant: Iva Lair
(b) Address: Gray Co O

17. (a) Coffey (Burial, cremation, or removal) (b) Date thereof: Jan 1 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Coffey Cemetery

18. (a) Signature of funeral director: Morehead's
(b) Address: Lancaster Mo

19. (a) Jan 6-42 (Date received local registrar) (b) E. E. Parish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30 year 1941 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec - 17, 1941, to Dec - 30, 1941, that I last saw him alive on Dec - 27, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial pneumonia	2 days
Due to Congestive heart failure	1 mo.
Chronic myocarditis	—
Due to Cerebral Hemorrhage	2 mo.
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) C
While at work? (e) Means of injury

23. Signature: E. E. Nichols (M. D. or other) 4/7/42
Address: Memphis Mo. Date signed 2-1-42

125 (Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

Primary Reg. Division District No. _____

Registration District No. _____

No. 2
4-17-39
5-1-39
1 x2415

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(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 address or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____ years _____ months _____ days

2. (a) PRINT FULL NAME _____

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 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 _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____

10. Usual residence _____

11. Industry or business _____

12. Birthplace _____ (State or foreign country)

13. Maiden name _____

14. Birthplace _____ (State or foreign country)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ A.M. P.M.

21. I hereby certify that I attended the deceased from _____, 19__ to _____, 19__ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____

Major findings of operation _____

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)

RECEIVED
District Health Officer No. 10
District File Number 1-42-101
Date Filed JAN 15 1942

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Minnie & True Morehead working under my personal supervision.

Signed True & Minnie Morehead

Licensed Embalmer No. 3680 -3731

P. O. Address Lancaster Mo.

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, fact should be so stated above.

(Licensed Embalmer's Statement on Reverse Side)

DUPLICATE FOR USE OF FUNERAL DIRECTOR

CHOICE TEMPLATE A EXAMINER BLACK INK—PRINT