

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **34548**FILED NOV 5 1943
Registration District No. **299**Primary Registration District No. **3948**Registrar's No. **37**

1. PLACE OF DEATH

- (a) County **Pike**
 (b) City or town **Ashley (Mo)**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1**

(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)3. (a) PRINT
FULL NAME**Best Anderson**

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

4. Sex **male** 2. Color or race **colored** 2. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife **Abby Anderson** 6. (c) Age of husband or wife if alive **15** years
 7. Birth date of deceased **1926**
 (Month) (Day) (Year)

8. AGE: Years **16** Months Days If less than one day
 hr. min.

9. Birthplace **Montgomery Co Mo**
 (City, town, or county) (State or foreign country)

10. Usual occupation **retired laborer**

11. Industry or business

12. Name **Anderson**
 13. Birthplace **Dont Know** 9
 (City, town, or county) (State or foreign country)
 14. Maiden name **Dont Know**
 15. Birthplace **Dont Know** 9
 (City, town, or county) (State or foreign country)

16. (a) Informant **Archie Moore**
 (b) Address **Ashley Mo**
 17. (a) **Burial** (b) Date thereof **Oct 15 1943**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Ashley Mo**

18. (a) Signature of funeral director **Frank Bankhead**
 (b) Address **Bonding Green Mo**
 19. (a) **Oct 25 1943** (b) **Mr Frank Gada**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **82** (b) County **2**
 (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 **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **14**
 year **1942** hour **6** minute **9** M.

21. I hereby certify that I attended the deceased from **April 1**
 19 **42** to **April 1** 19 **42**
 that I last saw him alive on **April 1**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Int Nephritis**
 Duration

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 sta-
 tistically.

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 **Frank Bankhead** (M. D. or other)
 Address **Bonding Green Mo** Date signed **10/19/43**

RECEIVED

District Health Officer No. 10

District File Number 11-42-1945

Date Filed NOV - 4 1942

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 the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 345-48Registration District No. 277Primary Registration District No. 5948Registrar's No. 57

1. PLACE OF DEATH:

- (a) County Pike
(b) City or town Ashley
(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)

3. (a) PRINT
FULL NAME Best Anderson

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married,
divorced W
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 86 Months _____ Days _____ If less than one day
min. _____

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

10. Usual occupation _____

11. Industry or business _____

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)
(Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
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 sta-
tistically.

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)

- (b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

1942

S-34548