

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6926

State File No.

FILED FEB 16 1943 200

Registration District No. 200

Primary Registration District No. 2723

Registrar's No. 3.

1. PLACE OF DEATH:

- (a) County Macon
(b) City or town Charlton 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

In this community.....

years, months or days)

3. (a) PRINT
FULL NAMEThomas Anderson

3. (b) If veteran,

name war.....

3. (c) Social Security

No.....

4. Sex

M

5. Color or

race W

6. (a) Single, widowed, married,

O divorced S

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if

alive..... years

7. Birth date of deceased

June 181870

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

7266

hr. min.

9. Birthplace.....

Mos O

(City, town, or county) (State or foreign country)

10. Usual occupation

Retired Farmer

11. Industry or business.....

12. Name

Matthew Anderson

13. Birthplace.....

Mos O

(City, town, or county) (State or foreign country)

14. Maiden name

Dennis

15. Birthplace.....

Mos O

(City, town, or county) (State or foreign country)

16. (a) Informant

Katie McMurry

(b) Address

Clifton Hill Mos

17. (a)

Burial

(b) Date thereof

12/26/42

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Salisbury Mos

18. (a) Signature of funeral director

Robert B. Krum

(b) Address

Macon

19. (a)

1/30/43

(Date received local registrar)

Jora B. Hunkler

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State
- Mo
- (b) County
- Macon

- (c) City or town
- Charlton 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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Dec
- day
- 24
-
- year
- 1942
- hour
- 2
- minute
- P
- M.

21. I hereby certify that I attended the deceased from
- Dec 24, 1942
-
- Dec 24
- , 1942 to
- Dec 24
- , 1942

that I last saw him alive on....., 19.....

and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma ofDigestive track

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 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?

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature
- F. L. Trippe
- (M. D. or other).....

Address College Mound Mo Date signed.....

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

RECEIVED

District Health Officer No. 10

District File Number 2-43-284

Date Filed FEB 15 1943

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

Albert Skinner

Licensed Embalmer No.

75-1

P. O. Address

Macon, Ga

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6926

Registration District No.

Primary Registration District No. 6-753

Registrar's No.

1. PLACE OF DEATH:

- (a) County Missouri
(b) City or town Rural
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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 Thomas Anderson

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 June 18 - 1870
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days _____ If less than one day _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 Missouri
(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I perceived him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to carcinoma of stomach digestive tract
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

