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1739
X29484

State File No. _____

Registration District No. 1

Primary Registration District No. 3100

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ellis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution entire life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirkville
(If outside city or town limits, write "RURAL")

(d) Street No. 415 So. Elson
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FLORENCE MAY ANDERSON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 19 year 1943 hour 12 minute 40 P.M.

21. I hereby certify that I attended the deceased from 2-13-43 to _____, 19____, to _____, 19____; that I last saw her alive on 2-19-43 and that death occurred on the date and hour stated above.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Charles E. Anderson 6. (c) Age of husband or wife if alive Dead years _____

7. Birth date of deceased 7 13 1864
(Month) (Day) (Year)

Immediate cause of death Lobar Pneumonia

Due to _____

8. AGE: Years 78 Months 9 Days 19 If less than one day _____ hr. _____ min.

Due to _____

9. Birthplace Mercer Co. Pa (City, town, or county) (State or foreign country)

Other conditions Bronchial catarrh
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations _____ Of autopsy _____

11. Industry or business _____

12. Name John H. Campbell

13. Birthplace Alleghany Co. Pa. (City, town, or county) (State or foreign country)

14. Maiden name Mary F. Barnhart

15. Birthplace Union Co. Pa. (City, town, or county) (State or foreign country)

16. (a) Informant Maudy Campbell

(b) Address 415 So. Elson

17. (a) _____ (b) Date thereof 2-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lowellyn Clear

18. (a) Signature of funeral director James R. Powell

(b) Address 415 So. Elson

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

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 R. R. Ellis (M. D. or other)
Address Kirkville Mo Date signed 2-20-43

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1049

JAN 22 1948

APR 30 1948

APR 1 1948

JAN 23 1948

RECEIVED

District Health Officer No. 10

District File Number 3-43-592

MAR 12 1948

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

W. C. Summer

Licensed Embalmer No.

2159

P. O. Address

Richsville

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9369
Registrar's No. 56

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Hospital
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Florence M. 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 April 13 1876
(Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 13 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

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) 3/3/43 (b) (Mrs) J. W. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
that I saw him _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death Cholera / Pneumonia 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

JUN 22 1943

AUG 7 1944