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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 18 1943

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 271

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:
Community Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether)

In this community Leflore 0
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair

(c) City or town Millard Mo.
(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 ALWY B. ANDERSON

3. (b) If veteran, name war None 3. (c) Social Security No. ✓

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

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

7. Birth date of deceased Jan 3 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

61 9 22 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Geo. Anderson

13. Birthplace Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Marjory Bogarth

15. Birthplace Adair Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Math Anderson

(b) Address Kirkville Mo R#1

17. (a) Burial (b) Date thereof 10-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ray Cem.

18. (a) Signature of funeral director Sumner Buell

(b) Address Kirkville Mo

19. (a) 11/3/43 (b) Mrs. J. Wayne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25
year 1943 hour Five minute 20 P.M.

21. I hereby certify that I attended the deceased from October 19 1943 to October 25 1943
that I last saw him alive on October 25 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia

Due to Fracture of left femur

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations No operation

Of autopsy No 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)
(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 A. H. Scholtz Registrar's No. 271
Address 23 E. Benton Kirkville Mo. Date signed 11/25/43

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

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

MOTHER FATHER

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 11-23-1860

Date Filed NOV 16 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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Turkville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Barboursville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 wks.
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Almy B. 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, divorced _____

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

7. Birth date of deceased Jan. 3 - 1885
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 1 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 _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 25
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

that I saw him/her _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis Pneumonia Duration _____

fracture of left femur

Due to _____

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) Accident

(b) Date of occurrence Sept. 26, 43

(c) Where did injury occur? Yarns Adm. Missouri
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Farm

While at work? No. (Specify type of place)
(e) Means of injury tripped by log

23. Signature C. R. Schultz (M. D. or other) _____

Address Community Nursing Home Date signed 9/18/49
Barboursville

SUPPLEMENTAL

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

37587