No. 2
5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 45036

FILED JAN 12 1944
Registration District No. 324

Primary Registration District No. 4475

Registrar's No. 224

1. PLACE OF DEATH:
(a) County Saline Co
(b) City or town Maltabend Mo
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Maltabend
(If outside city or town limits, write "RURAL")
(d) Street No. W Agness st
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME H ANDERSON
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex M
5. Color or race Negro
6. (a) Single, widowed, married, divorced /
6. (b) Name of husband or wife Phebe Anderson
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Aug (Month) 12 (Day) 1868 (Year)

8. AGE: Years 75 | Months 3 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Saline Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ~~Farmer~~
FATHER
12. Name Charley Anderson
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Alice Reed
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Phebe Anderson
(b) Address Maltabend Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Maltabend Cem
18. (a) Signature of funeral director J. D. Ferguson
(b) Address Ledulin Mo
19. (a) 12-11-43 (Date received local registrar) (b) Mo T.O. Westbrook (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from Dec 2, 1943 to Dec 10, 1943 that I last saw h. alive on Dec 9, 1943 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Lobar Pneumonia | 7 days |
| Due to: | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): Chr. Hypertension | |

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)
While at work? ..... (e) Means of injury .....

23. Signature [signature] (M. D. or other)
Address ..... Date signed 12/11/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 1-10-54

JAN 6 1954

## 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 T. O. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

**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.**

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 324 Primary Registration District No. 4475 Registrar's No. 227

**1. PLACE OF DEATH:**
(a) County Saline
(b) City or town Marshall
(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)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Saline
(c) City or town Marshall
(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 H 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 Married

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| 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 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)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-43896