

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8683

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3045**

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town **St. Louis, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Park Lane Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 days**
 (Specify whether
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County.....
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **7222 Calvin Ave.**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country..... **01**

3. (a) PRINT FULL NAME **Coran Anna Anderson,**
 3. (b) If veteran, name war. **No**
 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **30th**
 year **1944** hour..... minute..... M.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **3 Divorced**
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years

21. I hereby certify that I attended the deceased from
March 21st 1944 to March 30th 1944
 that I last saw her alive on **March 30th 1944**
 and that death occurred on the date and hour stated above.

7. Birth date of deceased **Feb. 3rd, 1899**
 (Month) (Day) (Year)

Immediate cause of death
Intestinal Obstruction Duration
2 weeks

8. AGE: Years **45** Months **I** Days **29**
 If less than one day hr. min.
 9. Birthplace **Nebraska**
 (City, town, or county) (State or foreign country)

Due to **gangrene & adhesions**
 Due to **adhesions from old operation**
 Other conditions.....
 (Include pregnancy within 3 months of death)

10. Usual occupation **Machine Operator**
U.S. Cartridge Plant
 11. Industry or business.....
 12. Name **James Andrus**
 13. Birthplace **Unknown** **9**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Margaret Reed**
 15. Birthplace **Unknown** **9**
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations **122**
 Of autopsy.....
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Gladys Jackson**
 (b) Address **7222 Calvin Ave.**
 17. (a) **Removal** (b) Date thereof **3/30/44**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Alton, Ill.**
 18. (a) Signature of funeral director **Kraeger-Voss-Fix**
 (b) Address **3402 N. Kingshighway**
 19. (a) **MAR 21 1944** (b) **J. J. Medeck**
 (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 **0**
 23. Signature **Clyde B. Kane** (M. D. or other) **MM-10**
 Address **705 Walters** Date signed **3/31/44**

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. W. Wilkinson*

Licensed Embalmer No. *3575*

P. O. Address.....

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.