

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11828**

FILED APR 12 1944

Registration District No. **3056**

Primary Registration District No. **3056**

Registrar's No. **68**

1. PLACE OF DEATH:

(a) County **Madison**
(b) City or town **mobility**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mc Cormick 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)

3. (a) PRINT FULL NAME **ANNA LORENE ALDERSON**

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **Female** 5. Color or race **col** 6. (a) Single, widowed, married, divorced, **Single**
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive, years
7. Birth date of deceased **1 2 1922**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
22 2 5 hr. min.

9. Birthplace **Jacksonville** (City, town, or county) **MO** (State or foreign country)

10. Usual occupation **house work**

11. Industry or business

12. Name **Bun Alderson**

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

14. Maiden name **Alice Tolson**

15. Birthplace **MO** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Alice Alderson**
(b) Address **mobility MO**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date of death **3/11/44**
(Month) (Day) (Year)
(c) Place: burial or cremation **mobility**

18. (a) Signature of funeral director **R. D. Carr**
(b) Address **417 N 3rd, mobility MO**
19. (a) **3/10/44** (Date received local registrar) (b) **Irma Rave** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Randolph**
(c) City or town **mobility**
(If outside city or town limits, write "RURAL")
(d) Street No. **225 Hedge Ave**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **7**
year **1944** hour **9** minute **P.M.**

21. I hereby certify that I attended the deceased from **3-7-1944** to **3-7-1944**
that I last saw her alive on **3-7-1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **third degree burn**
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) **accident 127**
(b) Date of occurrence **3/7/44**
(c) Where did injury occur? **mobility Randolph-MO**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)

While at work? **no** (e) Means of injury **Burn**

23. Signature **R. H. Williams** (M. D. or other)
Address **mobility MO** Date signed **3-9-44**

RECEIVED

District Health Officer No. 10

District File Number 4-44-769

Date Filed APR 11 1944

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.....

Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address.....

nobody. 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.