

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3146

FILED FEB 13 1945

Registration District No. 2147

Primary Registration District No. 3056

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Marion
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCook Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 12 days
In this community 17 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Martha Pierson Anderson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 2 divorced
(b) Name of husband or wife Robert E. Anderson 6. (c) Age of husband or wife if alive deceased
7. Birth date of deceased Oct 17-1860
(Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 14 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business at home

MOTHER FATHER { 12. Name Charles Pierson
13. Birthplace Reels Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Jane Shuff
15. Birthplace Reels Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant C. R. Anderson
(b) Address Marion, Mo

17. (a) Burial (b) Date thereof 1-4-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vandalia Cemetery

18. (a) Signature of funeral director Paul Thompson
(b) Address Marion, Mo

19. (a) 1-4-45 (b) Irma Nave
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Vandalia 4
(If outside city or town limits, write "RURAL") 2
(d) Street No. 1 (If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1st
year 1945 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec. 16
1944 to Jan 1 1945
that I last saw her alive on Jan 1 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Carcinoma of bowels - colon 3 months

Due to Carcinoma of bowels - colon 3 months

Due to —

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 462

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 G. L. McCormick (M. D. or other)
Address Marion, Mo Date signed 1-1-45

(Licensed Embalmer's Statement on Reverse Side)

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

1036

RECEIVED

District Health Officer No. 10

District File Number 2-45-305

Date Filed FEB 11 1945

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

Mrs. L. H. Thompson

Licensed Embalmer No.

3282

P. O. Address

Madison, 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: