

S. No. 2
M-543
y. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED AUG 24 1945 STANDARD CERTIFICATE OF DEATH

25378

State File No. _____
Registrar's No. 7130

Registration District No. 318 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 30 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 17 11
(d) Street No. 4269 Enright (If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Glaud Anderson
3. (b) If veteran name war _____ 3. (c) Social Security No. 489-18-9654

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 11,
year 1945 hour 6 minute 05 A.M.
21. I hereby certify that I attended the deceased from August
8, 1945, to August 11, 1945.
that I last saw him alive on August 11, 1945
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of Face Negro
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Ada Anderson 6. (c) Age of husband or wife if
alive 45 years
7. Birth date of deceased September 20th 1898
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Larynx
Duration Unk.
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
46 10 21 _____hr. _____min.

9. Birthplace Holly Springs Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Door-Man

11. Industry or business Park Plaza Hotel

12. Name Will Anderson
13. Birthplace Holly Springs Mississippi
(City, town, or county) (State or foreign country)
14. Maiden name Della Sanders
15. Birthplace Holly Springs Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Fannie Buchanan
(b) Address 4518 Evans

17. (a) Burial (b) Date thereof 8/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Ave.

19. (a) AUG 14 1945 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

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 J. P. Stearns (M. D. _____)
Address 260 N. 3rd Street Date signed 8/14/45

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

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

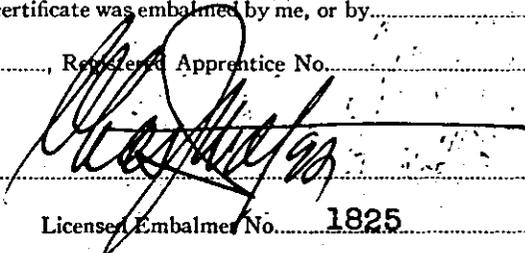
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Charles. J. Gates.....

Registered Apprentice No.....

working under my personal supervision.

Signed.....



License/Embalmer No. **1825**.....

P. O. Address: **4107 Finney Ave.**.....

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.