. S. No. 2
OM—2-43
v. 5-17-39

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

25380

State File No.

FILED SEP 1 1945

Registration District No. 318

Primary Registration District No. 100

Registrar's No. 7303

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: Mo-Baptist
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1½ Mo. (Specify whether
In this community 1½ Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford 28

(c) City or town Cuba 1
(If outside city or town limits, write "RURAL")

(d) Street No. N.R. 3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Russell Fletcher Anderson

3. (b) If veteran, name war ?

3. (c) Social Security No. no

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife Ethel

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Mar (Month) 3 (Day) 1895 (Year)

8. AGE: Years 50 | Months 5 | Days 16 | If less than one day ___ hr. ___ min.

9. Birthplace Cuba (City, town, or county) Missouri. 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

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

MOTHER
14. Maiden name Eva Fickle
15. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Mrs Ethel Anderson
(b) Address Cuba, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Cuba, Missouri

18. (a) Signature of funeral director Alexander & Sons
(b) Address 6175 Delmar Blvd

19. (a) AUG 21 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19th
year 1945 hour ___ minute ___ M.

21. I hereby certify that I attended the deceased from May 29, 1945 to Aug 19, 1945
that I last saw him alive on Aug 19, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Chr / Hypertension Chr / myocarditis Chr — Duration about 2 years

Due to —

Due to —

Other conditions — (Include pregnancy within 3 months of death) 131

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 Robert G Warren (M. D. or other) M.D.
Address Paul Brown Bldg Date signed Aug 20 45

(Licensed Embalmer's Statement on Reverse Side)

Dr Robert Warner
Paul Brown Bldg
10 30 to 3 PM

JUN 18 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 Thomas R. Fenwick

Licensed Embalmer No. 3793

P. O. Address St Louis, 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.