S. No. 2
0M—2-43
v. 5-17-39
I X35597

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

44-70

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 28 1945

State File No. 28375

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 91062

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether
In this community 45 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4348 Ashland
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ANDERSON, Jesse
3. (b) If veteran, name war World I
3. (c) Social Security No.
4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hosea Anderson
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased April 1 (Month) 1891 (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	54	5	13	hr. min.

9. Birthplace (City, town, or county) Louisiana (State or foreign country)
10. Usual occupation Laborer
11. Industry or business --
FATHER
12. Name Louis Anderson
13. Birthplace Harris, (City, town, or county) Mississippi (State or foreign country)
MOTHER
14. Maiden name Annie Jones
15. Birthplace Red Lick (City, town, or county) Mississippi (State or foreign country)
16. (a) Informant Clinical Clerk, Vet. Adm. Fac.,
(b) Address Jefferson Barracks, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.
18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Ave.
19. (a) 8-21-45 (Date received local registrar) (b) E. G. McGarran M.D. (Registrar's signature) No 56

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14
year 1945 hour 5:50 minute A. M.
21. I hereby certify that I attended the deceased from August 3, 1945 to August 14, 1945;
that I last saw him alive on August 14, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death TUBERCULOSIS, (LUNGS, INTESTINES AND PERITONIUM).	Unknown
Due to --	
136	
Due to --	
Other conditions -- (Include pregnancy within 3 months of death)	

Major findings:
Of operations Exploratory operation, date unknown, at Homer Phillips Hospital.
Of autopsy No 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) No
(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 E. V. EDWARDS, LT. COL., (M. D. or other) M.C., Clinical Director.
Address Vet. Adm. Fac., Jeff. Brks., Mo. Date signed 8/14/45

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(Licensed Embalmer's Statement on Reverse Side)

OCT 15 1945

JAN 29 1946

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 _____

Licensed 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.