

S. No. 2
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

31312

FILED OCT 15 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registrar's No. 2054

Registration District No. 301

Primary Registration District No. 445D

1. PLACE OF DEATH:

(a) County RIPLEY,

(b) City or town DONIPHAN.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
AT HOME OF JOE GARY, DONIPHAN.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community 18 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County ripley, 91

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

(d) Street No. _____
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME HAROLD SMITH ANDERSON.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE (1) 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED.

6. (b) Name of husband or wife DECEASED.

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

7. Birth date of deceased APRIL 12, 1871.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74. 5. 9. _____ hr. _____ min.

9. Birthplace OAKLAND, CALIFORNIA.
(City, town, or county) (State or foreign country)

10. Usual occupation TOOL & DIE MAKER.

11. Industry or business SILVERSMITH.

MOTHER FATHER { 12. Name ANDERSON.

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant MRS JOE GARY,

(b) Address DONIPHAN, MO.

17. (a) BURIAL (b) Date thereof 9-23-45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Doniphan, Mo.

18. (a) Signature of funeral director F. E. Jordan.

(b) Address Doniphan, Mo.

19. (a) 10-10-45 (b) F. B. Johnston
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, 21
year 1945, hour 9:00 minute _____ A. M.

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

Immediate cause of death _____
Coronary Thrombosis

Due to Hypertension

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) _____

(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)

(c) Means of injury _____

23. Signature F. B. Johnston (M. D. or other) _____

Address Doniphan, Mo. Date signed 9-24-45

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

674

RECEIVED

District Health Officer No. 5,

District File Number 1045-5-30

Date Filed 10.13.45

OCT 19 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 J. E. Jordan
Licensed Embalmer No. 32021
P. O. Address Doniphan

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.