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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33278
Registrar's No. 285

FILED NOV 3 6 1945
Registration District No. 73

Primary Registration District No. 5143

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

1. PLACE OF DEATH:

(a) County BUTLER

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

(c) Name of hospital or institution: 9 mi. S.E. Poplar Bluff
(If not in hospital or institution, write street number or location)

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

In this community 6 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BUTLER 12

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

(d) Street No. 9 MI. SE. POPLAR BLUFF
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN ANDERSON

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

4. Sex MALE 5. Color of race WHITE

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

6. (b) Name of husband or wife IDA ANDERSON

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased JULY 29 1866
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 25 year 1945 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from 9/20 1945, to 9/24 1945, that I last saw him alive on 9/24/45 and that death occurred on the date and hour stated above.

Immediate cause of death Left Ventricular failure Duration _____

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

79 1 26 _____ hr. _____ min.

Due to Chronic myocarditis

Due to _____

9. Birthplace _____ (City, town, or county) (State or foreign country) KY 1

10. Usual occupation FARMER

11. Industry or business _____

12. Name W.M. ANDERSON

13. Birthplace _____ (City, town, or county) (State or foreign country) KY 1

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country) KV 1

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.

16. (a) Informant Nora Denton

(b) Address BROSBLEY MO RD #1

17. (a) BURIAL (b) Date thereof SEPT 26 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation POMBAUER CEM.

18. (a) Signature of funeral director N.T. PHELPS

(b) Address POPLAR BLUFF MO

19. (a) 10/10/45 (b) R.H. Nunelee
(Data received local registrar) (Registrar's signature)

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 Gordon C. Shields (M. D. or other) D.O.

Address FISK, MISSOURI Date signed 9/28/45

1422

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 1045314

Date Filed 10-31-42

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 N. T. Phelps

Licensed Embalmer No. 3231

P. O. Address Pepler Bluff 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 43

Primary Registration District No. 5143

Registrar's No. 285

1. PLACE OF DEATH:

(a) County Butler

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

(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

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

In this community _____ (years, months or days)

3. (a) PRINT FULL NAME John Anderson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased July 29 1884
(Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

(e) Citizen of foreign country? _____ (Yes or No) If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 29 Year 1963 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

33278