

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40397**
Registrar's No. **70**

FILED JAN 8 1946

Registration District No. **11**

Primary Registration District No. **5044**

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Washburn** *Washburn*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **Minnie Anderson**

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

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Simp Anderson** 6. (c) Age of husband or wife if alive **47** years
7. Birth date of deceased **January 18 1901**
(Month) (Day) (Year)

8. AGE: Years **44** Months **9** Days **29** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John T. Vanzandt**

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

14. Maiden name **Susie Miller**

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

16. (a) Informant **Simp Anderson**

(b) Address **Washburn, Missouri**

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

(c) Place: burial or cremation **Roller Cemetery**

18. (a) Signature of funeral director **Culver Funeral Home**

(b) Address **Cassville, Missouri**

19. (a) **Dec 12 - 1945** (b) **Grace Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
(c) City or town **Washburn**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **17**th
year **1945** hour **10:00 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **Nov 14**,
1945, to **Nov 17**, 1945.
that I last saw her alive on **Nov 17**, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Pneumonia

Due to _____

Due to **flu**

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

Major findings: _____
Of operations _____

Of autopsy _____

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 **2**

23. Signature **Dr. C. R. Brown** Date signed **11/19/45**

Address **Seligman, Mo**

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 6,

District File Number 1245-1116

Date Filed 12-27-45

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

Margaret Culver

Licensed Embalmer No. 4389

P. O. Address Cassville

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.