

17-39
X38671

FILED APR 22 1946

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 55

1. PLACE OF DEATH:

(a) County AUDRAIN
(b) City or town MEXICO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
331 West PROMADE STREET
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME FRANK MAGNUS ANDERSON

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

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased OCTOBER 8 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>5</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Car Repair Work Retired

11. Industry or business C.B. & Q Railroad Co

MOTHER, FATHER {
12. Name Dont Know
13. Birthplace Dont Know
(City, town, or county) (State or foreign country)
14. Maiden name Dont Know
15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant Dr J Anderson
(b) Address Willecke Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-2-46
(Month) (Day) (Year)

(c) Place: burial or cremation STOUTSVILLE CEMETERY

18. (a) Signature of funeral director Wilson's Sons
(b) Address MONROE CITY Mo

19. (a) 4/2/46 (Date received local registrar) (b) Blanche Keely (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONROE ⁶⁹
(c) City or town RURAL ⁰
(If outside city or town limits, write "RURAL")
(d) Street No. STOUTSVILLE MO ⁰
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 29
year 1946 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from March 28
1946 to March 29 1946
that I last saw him alive on March 28 1946
and that death occurred on the date and hour stated above

Immediate cause of death Cardiac failure ^{Duration 30 min}

Due to infirmitie of age ^{1 yr.}
& anemia

Due to _____

Other conditions (include pregnancy within 3 months of death)

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

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) (e) Means of injury _____

23. Signature Dr Kallenbach (M. D. or other) ⁰
Address 1196 Jackson, Mexico Date signed 4/2/46
Mo

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

RECEIVED

Health Officer No. 170

4-46-7787

APR 19 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 *me*

....., Registered Apprentice No.

working under my personal supervision.

Signed *Levie L. Wilson*

Licensed Embalmer No. *3514*

P. O. Address *Monroe City, 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. May
Registrar's No. 558

Registration District No. 10 Primary Registration District No. 0002

1. PLACE OF DEATH:

(a) County Andraan
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(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 Frank M. Anderson

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

4. Sex M 5. Color W 6. (a) Single, widowed, married, divorced wid
race _____

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

7. Birth date of deceased Oct 8 1908
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 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 May 29
year 1946 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 Cardiac failure Duration Sudden

Due to infirmitas of age
partially due to malnutrition
Due to and avitaminosis.

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

Major findings:
Of operations _____

Of autopsy 16 vls

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 H. P. Ballenbach (M. D. or other) _____

Address 119 E. Jackson, Mexico, Mo Date signed 4-26-46

11009 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

12100