

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20851

State File No.

FILED 10/10/1946

Registration District No.

Primary Registration District No.

5632

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town RURAL DEARBORN TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: OAKLAND MO 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 1 WK
years, months or days

3. (a) PRINT FULL NAME GERTRUDE C. ANDERSON

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased DONT KNOW
(Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days _____ If less than one day
hr. _____ min. _____

9. Birthplace LACLEDE CO MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE KEEPER

11. Industry or business

12. Name JOHN CONNER
13. Birthplace LACLEDE CO MO
(City, town, or county) (State or foreign country)
14. Maiden name ELLA BACON
15. Birthplace MISS.
(City, town, or county) (State or foreign country)

16. (a) Informant ROBT. WILSON
(b) Address OAKLAND MO
17. (a) REMOVAL (b) Date thereof 6-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation AURORA MO

18. (a) Signature of funeral director KING FUNERAL HOME
(b) Address AURORA MO

19. (a) 6-12-46 (b) DR. Frankenberg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State OKLA (b) County Not known
(c) City or town TULSA
(If outside city or town limits, write "RURAL")
(d) Street No. 717 S. PHOENIX
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 9
year 1946 hour 2 minute 1 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 CORONARY THROMBOSIS
Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy 940

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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature DR. Frankenberg (M. D. or other) 13
Address Tulsa Mo. Date signed 9/9/46

(Licensed Embalmer's Statement on Reverse Side)

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

Received 7-5-46
Laclede County Health Unit
File No. 6-46-88
Date Filed 7-8-46

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.....

W. B. Palmer

Licensed Embalmer No. 1161

P. O. Address. Lanham 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.