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M-8-43
5-17-39
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23201

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

Registration District No. 286 Primary Registration District No. 5-404-4178

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.
22057

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Holcomb
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 43 year (Specify whether years, months or days)

3. (a) PRINT FULL NAME William A. Anderson
3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 2 divorced widowed
(b) Name of husband or wife Susan Rhody Anderson deceased 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 4 1859 (Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Not Known Tenn (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER, FATHER { 12. Name John C. Anderson
13. Birthplace Not Known Alabama (City, town, or county) (State or foreign country)
14. Maiden name Lucinda Sullins
15. Birthplace Not Known USA (City, town, or county) (State or foreign country)

16. (a) Informant J. A. Anderson
(b) Address Holcomb, Mo

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-46 (Month) (Day) (Year)

(c) Place: burial or cremation Burial Stanfield

18. (a) Signature of funeral director Anderson Funeral Home
(b) Address Campbell Mo

19. (a) 4-24-46 (b) J. A. Anderson (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town Holcomb Mo (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 23rd day April
year 1946 hour 5 minute 10 A M.
21. I hereby certify that I attended the deceased from Feb. 27th 1946 to Apr. 23rd 1946
that I last saw him alive on Apr. 23rd 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Failure of Heart Duration 1 hr.

Due to Arterial Hypertension ?

Due to _____

Other conditions Senility (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 _____

23. Signature Wallace Selby (M. D. or other) MD
Address Campbell 4-24-46 (City, town, or county) (State)

PHYSICIAN
Underline the cause to which death should be charged statistically.

89

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 446-847

Date Filed 2-15-46

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.