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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 22 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25915

Registration District No. 3213 Primary Registration District No. 4474 Registrar's No. 71

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

1. PLACE OF DEATH:
(a) County SALINE
(b) City or town SWEET SPRINGS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 200 W. RAY ST.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County SALINE
(c) City or town SWEET SPRINGS.
(If outside city or town limits, write "RURAL")
(d) Street No. 200 W. RAY ST
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WALKER W. 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 SINGLE

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

7. Birth date of deceased DEC. (Month) 18 (Day) 1866 (Year)

8. AGE: Years 79 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace SWEET SPGS. (City, town, or county) MO (State or foreign country)

10. Usual occupation
11. Industry or business Disabled Mentally

MOTHER FATHER
12. Name JAS. F. ANDERSON
13. Birthplace CARROLTON (City, town, or county) MO (State or foreign country)
14. Maiden name MARGRETE REMBERT
15. Birthplace MEMPHIS (City, town, or county) TENN (State or foreign country)

16. (a) Informant Sally Anderson
(b) Address Sweet Springs Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7/8/46 (Month) (Day) (Year)
(c) Place: burial or cremation FAIRVIEW CEMETERY

18. (a) Signature of funeral director P. C. CARTER
(b) Address SWEET SPRINGS. MO

19. (a) 7/8/46 (Date received local registrar) (b) Addie Anderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 6
year 1946 hour 7 minute 10 A. M.

21. I hereby certify that I attended the deceased from July 6, 1946, to July 6, 1946, that I last saw him alive on July 6, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Arteriosclerosis	
Due to	
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.

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 Chas. L. Parsons (M. D. or other) M.D.
Address Sweet Springs Mo Date signed 7/8/46

243 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 2-20-46

—WYKE

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 R C Porter

Licensed Embalmer No. 3513

P. O. Address Lewisburg W Va

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 446

Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 71

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Sweet Springs
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Walker W. 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec 18 1866 (Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business Disabled mentally

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Dolly Anderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January year 1946 hour [illegible] minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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.

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

25915