

S. No. 2  
DM-8-43  
v. 5-17-39  
X37823

35958

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 25 1946

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

Registrar's No. 407

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkville mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Stickler 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Schuyler

(c) City or town Dorning  
(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 Oscar Leroy Anders

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11  
year 46 hour 4:00 minute 30A M.

21. I hereby certify that I attended the deceased from Nov. 9, 1946, to Nov. 11, 1946  
that I last saw him alive on Nov. 10, 1946  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: June 25 1886  
(Month) (Day) (Year)

Immediate cause of death: Peritonitis Duration 3 days

Due to Groederal ulcer Ruptured 1 wk.

Due to Arthritis Rheumatoid 3 yrs

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 55 Months 5 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Schuyler Co mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Business man

Major findings: Of operations \_\_\_\_\_

Of autopsy 117B

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name John Anders

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

14. Maiden name June Eston

15. Birthplace Schuyler Co mo  
(City, town, or county) (State or foreign country)

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 R. P. Stickler (M. D. or other) MD  
Address Kirkville mo Date signed 11-11-46

16. (a) Informant Hlo Anders

(b) Address Dorning mo

17. (a) burial (b) Date thereof 11-12-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coffin

18. (a) Signature of funeral director Ray Moore

(b) Address Dorning mo

19. (a) 11-12-46 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

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

34730

RECEIVED  
District Health Officer No. 19  
District File Number *10-46-2076*  
Date Filed *NOV 22 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 *Lloyd Moore*

Licensed Embalmer No. *3151*

P. O. Address *Downing 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.