. S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 4 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37556

Registration District No. 174 Primary Registration District No. 56454 Registrar's No. 68

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: 6 mi S Lexington (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 60 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette

(c) City or town Lexington (If outside city or town limits, write "RURAL")

(d) Street No. 6 mi S. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ida Anderson.

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Fe

5. Color or race W

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

6. (b) Name of husband or wife Aug Anderson

6. (c) Age of husband or wife if alive 88 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 28 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Gustav Bloom
13. Birthplace (City, town, or county) Sweeden (State or foreign country)

MOTHER
14. Maiden name not known
15. Birthplace (City, town, or county) Sweeden (State or foreign country)

16. (a) Informant Oscar Anderson

(b) Address Lexington, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-46 (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Mo

18. (a) Signature of funeral director Farrest F. Tempel

(b) Address Lexington, Mo

19. (a) 20 Nov 1946 (Date received local registrar) (b) Nelson E. Eustatiowski (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 11 day 14 year 1946 hour 12 minute noon M.

21. I hereby certify that I attended the deceased from called as acting Coroner, 19 ; that I last saw her alive on 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Probably Coronary Occlusion

Due to died suddenly, choked on drink of water & died immediately.

Due to Death due to natural causes

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no operation

Of autopsy no autopsy

Duration

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) no accident

(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 W E Martin MD acting Coroner (M.D. or other)

Address Dessa Mo Date signed 11-14-46

156 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-30-46

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 Geo. McLean

Licensed Embalmer No. 2983

P. O. Address Franklin, Ore.

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.