

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 71

Primary Registration District No. 3012

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

1. PLACE OF DEATH:

(a) County Clay

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

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

(d) Length of stay: In hospital or institution 15 days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Sac

(c) City or town Schaller
(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 Glen William 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 Married

6. (b) Name of husband or wife Alta B.

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased September 19, 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

45	2	23	hr. min.
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9. Birthplace River Sioux, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Agent telegrapher

11. Industry or business Northwestern Railroad

12. Name Nels Anderson

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

14. Maiden name Charlotte Brunstedt

15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. W. Anderson

(b) Address Schaller, Iowa

17. (a) Removal (b) Date thereof 12-13-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Schaller, Iowa
Claude Prichard

18. (a) Signature of funeral director _____
(b) Address Excelsior Springs, Missouri

19. (a) 12/12/46 (b) Baroline Hutchings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12
year 1946 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from 27 November
1946 to 12 Dec 1946
that I last saw h. in alive on 12 Dec 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Mesenteric Thrombosis Duration 5 days.

Due to Rupture of Cecum Acute appendicitis 2 wks.

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy Rupture Cecum - Multiple
Mesenteric Thrombosis - Left Engorged

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? _____

23. Signature E. B. Robinson (M. D. or other) M.D.
Address Excelsior Springs Mo Date signed 12-12-46

RECEIVED

District Health Officer No. 8.

District File Number.....

Date Filed 12-21-46

NOV 11 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Spgs, 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.