

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43800

State File No.

Registrar's No.

21

Registration District No.

333

Primary

District No.

3074

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(c) Name of hospital or institution: 301 So. Scott St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community 40 yrs
years, months or days)

3. (a) PRINT FULL NAME

CARRIE ANN ANDERSON

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife 6. (c) Age of husband or wife if
alive years
7. Birth date of deceased April 7 1875
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 17 If less than one day
hr. min.

9. Birthplace Meach County Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown
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 Ingomar Anderson
(b) Address Sikeston, Mo

17. (a) Burial (b) Date thereof 8-26-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo

18. (a) Signature of funeral director Taylor Funeral Home
(b) Address Sikeston, Mo

19. (a) 8-29-47 (b) Mr. T. F. Henry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 301 So. Scott St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
year 1946 hour Two minute 50 P M.

21. I hereby certify that I attended the deceased from 8-24-46
19 to 8-24-46 19
that I last saw her alive on 8-24-46 19
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 0

23. Signature E. D. Urban (M. D. or other) M. D.
Address Sikeston, Mo Date signed 10/26/46

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

303

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2

District File Number 447-46

Date Filed 4-3-47

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.....

James M. Scott

Licensed Embalmer No. 4350

P. O. Address East Prairie, 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.