

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3860**

FILED MAR 12 1947

Registration District No. **6**

Primary Registration District No. **5031**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **Audrain**
(b) City or town **Farber "Rural" Cuivre**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 Miles West 1 mi North of Farber
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1** (Specify whether years, months or days)
In this community **34 years**

3. (a) PRINT FULL NAME **JAMES THOMAS ANDERSON**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Bertha F. Anderson** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **May 23 1885**
(Month) (Day) (Year)

8. AGE: Years **61** Months **8** Days **26** If less than one day hr. min.

9. Birthplace **Montgomery County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farming**

12. Name **James Anderson** **Mo**

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

14. Maiden name **Martha Williams**

15. Birthplace **Montgomery county Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bertha F. Anderson**

(b) Address **Farber, Mo**

17. (a) **Burial** (b) Date thereof **2/21/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ladsonia, Mo.**

18. (a) Signature of funeral director **W. S. Waters**

(b) Address **Vandalia, Mo**

19. (a) **Feb 21, 1947** (b) **Mallic Fugard**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Audrain**
(c) City or town **Farber "Rural" Cuivre**
(If outside city or town limits, write "RURAL")
(d) Street No. **2 miles west, 1 mile north of FARBER** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **19** year **1947** hour **12** minute **30 A** M.

21. I hereby certify that I attended the deceased from **Sep 10** 1946 to **Feb 19** 1947
that I last saw him alive on **Feb 19** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Lung** Duration **1 yr.**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 **2**

23. Signature **PTB** (M. D. or other) **DO**

Address **Ladsonia, Mo** Date signed **2-21-47**

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

RECEIVED
DEPT. HEALTH Officer No. 10
Bureau File Number 3-41-470
Date Filed MAR 11 1947

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.....

Thos. B. Waters

Licensed Embalmer No.....

4169

P.O. Address.....

Vandalia 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.