

No. 2
-12-45
5-17-39
I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

78777

State File No. _____

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

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

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone 10

(c) City or town Centralia
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME Evang. Anderson Jr.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, Divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 30 1874
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>72</u> | <u>9</u> | <u>2</u> | hr. _____ min. _____ |

9. Birthplace Menard Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Evang. S. Anderson

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

14. Maiden name Eleanora Sams

15. Birthplace Audrain Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Gussie Anderson

(b) Address Centralia Mo

17. (a) Burial (b) Date thereof Feb 23 '47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia

18. (a) Signature of funeral director Chas. Jensen

(b) Address Centralia Mo

19. (a) 3/15/47 (b) Maud McBride
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 22
year 1947 hour 2 minute 20 A. M.

21. I hereby certify that I attended the deceased from Feb. 20
1946, to Feb. 22, 1947

that I last saw him alive on Feb. 22, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 8 yrs

Due to Arterial hypertension

Due to _____

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

Major findings:
Of operations 93D

Of autopsy _____

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) _____

(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 0

23. Signature Lehold Leclaire (M. D. or other) M.D.

Address Centralia, Mo Date signed 3-14-47

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 3-20-47

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 *Gron Fernandez*
Licensed Embalmer No. 4270
P. O. Address Centralia, 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.