S. No. 2
-11-10-39
5-17-39
PI X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 23 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23682

Registration District No. 67 Primary Registration District No. 5265 Registrar's No. 6

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Oldfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Christian
(c) City or town Oldfield
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME William Harvey 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 Widowed
6. (b) Name of husband or wife Grace Fae Chaffin 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Nov (Month) 27 (Day) 1874 (Year)

8. AGE: Years 73 Months 6 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace Scott Co. (City, town, or county) Virginia (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ____
FATHER 12. Name Hiram P. Anderson
13. Birthplace Don't Know (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mary Jane Bloomer
15. Birthplace don't Know (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Gene Harvill
(b) Address Oldfield, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation Linden cemetery
18. (a) Signature of funeral director John Harris
(b) Address Chadwick Mo
19. (a) June 26-47 (Date received by local registrar) (b) Lillie Barr (Registrar's signature) 5X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 16 year 1947 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from May 6 21, 1947, to June 16, 1947 that I last saw him alive on June 17, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension	unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. R. Fathing (M. D. or other)
Address Ozark Mo Date signed 6-18-47

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 6
District File Number 747-732
Date Filed ~~JUN 21 1917~~

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 T. B. Chaffin

Licensed Embalmer No. 2182

P. O. Address Ozark 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, above space should be left blank.