

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

**FILED JUL 21 1948**

Registration District No. \_\_\_\_\_  
Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution St. Louis Children's Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
Specify whether \_\_\_\_\_

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Tim Anderson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased July 15 1946  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>11</u>	<u>23</u>	hr. _____ min. _____

9. Birthplace Herrin, Ill.; Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Clyde Anderson

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

14. Maiden name Dora Owens

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

16. (a) Informant Clyde Anderson  
(b) Address Carterville, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-9-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Marion, Ill.

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.

19. (a) JUL 10 1948 (Date received local registry) J. F. Bredaek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Williamson

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

(d) Street No. RFD 2  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8  
year 47 hour \_\_\_\_\_ minute 8 P.M.

21. I hereby certify that I attended the deceased from 7-2-47 to 7-8-47  
that I last saw him alive on 7-8-47  
and that death occurred on the date and hour stated above.

Immediate cause of death congenital heart disease (retrology of valve) postoperative life  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 157

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. J. Bluffner (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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**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

*Ernest W. Spillers*  
.....  
Licensed Embalmer No. *14080*

P. O. Address.....

**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.**