

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26502

Registration District No. 349

Primary Registration District No. 4814

Registrar's No. 19

1. PLACE OF DEATH:

(a) County SULLIVAN
(b) City or town Green City
(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)
In this community LIFE years, months or days

3. (a) PRINT FULL NAME ARMON O ANDERSON

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife LIZZIE ANDERSON 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased 2 (Month) - 28 (Day) - 1878 (Year)

8. AGE: Years 69 Months 4 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name W. C. Anderson

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

14. Maiden name Mary McLaughlin

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

16. (a) Informant W. C. Anderson

(b) Address Green City

17. (a) Burial (b) Date thereof 7-27-1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director W. C. Anderson

(b) Address Green City Mo

19. (a) Aug 2-47 (b) Laura Shaw (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Green City (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25 year 1947 hour 8 minute 20 M.

21. I hereby certify that I attended the deceased from July 1946 to July 25, 1947
that I last saw him alive on July 25, 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Cancer of Stomach

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 46B

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? 2

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

23. Signature W. Herington (M. D. or other) _____

Address Green City Mo Date signed 7-29-47

RECEIVED
District Health Officer No. 10
District File Number 8-47993
Date Filed AUG - 4 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... *Archie W. Wade*

Licensed Embalmer No. *3037*

P. O. Address... *Green City, 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.