

No. 2
1/47
5-17-39

28478

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 28 1947

Registration District No. 257

Primary Registration District No. 3048

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Nodaway

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

(c) Name of hospital or institution St. Francis
(If not in hospital or institution, write street name and location)

(d) Length of stay: In hospital or institution 3 weeks
40 yrs (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison

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

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

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

3. (a) PRINT FULL NAME Anna L. Anderson

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Female

5. Color or race white

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

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

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

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

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>10</u>	<u>28</u> hr. min

9. Birthplace Page Co Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business Samuel Mitchell

12. Name.....

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

14. Maiden name Elizabeth Green

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

16. (a) Informant Jess B Cowman

(b) Address Fairfax Mo

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

(c) Place: burial or cremation Tarkio Home Cemetery

18. (a) Signature of funeral director J M Davis

(b) Address South Mo.

19. (a) Aug 11-47 (b) Bess Holtz
(Date received local registrar) (Registrar's name)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
year 1947 hour 8 minute PM

21. I hereby certify that I attended the deceased from Jan 1 1947 to Aug 5 1947
that I last saw her alive on Aug 4 1947
and that death occurred on the date and hour stated above.

Immediate cause of death peritonitis secondary to carcinoma
Duration 3 days

Due to.....

Due to.....

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

Major findings:
Of operations Carcinoma masses throughout abdomen
Of autopsy in January

PHYSICIAN
Underline name of physician
S.D.P. which shall be filed in the
STATISTICAL
INVESTIGATION
REQUESTED

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 J. C. Bauman (M. D. or other) M.D.

Address 13 S. Main Maryville Date signed 8/8/47

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 _____

Frost G. Browning

Licensed Embalmer No. _____

3338

P. O. Address _____

Jarvis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Marionville
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Anna L. Anderson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Sept (Month) 2 (Day) 1904 (Year)

8. AGE: Years 12 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Lewia (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Sept Day 14 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to primary site probably may

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

PHYSICIAN

Major findings: Of operations _____ Of autopsy H9A

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) _____ Means of injury _____

23. Signature W. E. Bunn (M. D. or other) M.D.
Address Marionville Date signed 8/20/44

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

SUPPLEMENTARY

S-28478