S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30264

FILED OCT 15 1947

Registration District No. .... Primary Registration District No. 3003 Registrar's No. 62

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Monett Hospital (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Monett Hospital - St. Vincents (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 weeks (Specify whether years, months or days)
In this community ....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jasper
(c) City or town Sarcoxie (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 ....

3. (a) PRINT FULL NAME John W. Anderson
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 W
6. (b) Name of husband or wife Deceased
6. (c) Age of husband or wife if alive .... years
7. Birth date of deceased Nov. 24 1871 (Month) (Day) (Year)
8. AGE: Years 76 Months 9 Days 12 If less than one day .... hr. .... min.
9. Birthplace unknown (City, town, or county) (State or foreign country)
10. Usual occupation retired plumber
11. Industry or business ....
FATHER 12. Name unknown
13. Birthplace .... (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace .... (City, town, or county) (State or foreign country)
16. (a) Informant Geo. Anderson
(b) Address Sarcoxie, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation Sarcoxie Cemetery
18. (a) Signature of funeral director W. K. Jackson
(b) Address Sarcoxie Mo.
19. (a) 9-8-47 (Date received local registrar) (b) W. M. West (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 6 year 1947 hour 3 minute 56 P. M.
21. I hereby certify that I attended the deceased from June 28 1947, to Sept 6 1947, that I last saw him alive on Sept 6 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic pneumonia & Chronic interstitial nephritis	10 days / Indefinite
Due to	
Due to	
Other conditions Fracture surgical neck of Rt. femur 6-28-47 (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident fall
(b) Date of occurrence 6-28-47
(c) Where did injury occur? Sarcoxie Lawrence Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In yard at home (Specify type of place)
While at work? No (e) Means of injury Fall
23. Signature Robert A. Donley (M. D. or ....) M.D.
Address Monett, Mo. Date signed 9-7-47

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

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6;
District File Number 1047-1031
Date Filed OCT 10 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 JMQ
....., Registered Apprentice No.....,
working under my personal supervision.

Signed Wm H. Jackson
Licensed Embalmer No. 3954
P. O. Address Lancaster Ohio

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.