

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 hrs. 45 min.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2333 No. Concord  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Baby Anderson

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

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced S U

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

7. Birth date of deceased 11 (Month) 9 (Day) 1947 (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 hr. 45 min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name James Elvin Anderson

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

14. Maiden name Byrdine Jeanette Haile

15. Birthplace De Soto (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. J. E. Anderson

(b) Address 2333 No. Concord

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Oldfield Mission

18. (a) Signature of funeral director Frank C. ...

(b) Address Springfield, Mo.

19. (a) 11-12-47 (Date received local registrar) (b) W. S. Handley, MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11 year 1947 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11-10 1947, to 11-11 1947 that I last saw her alive on 11-10 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (27 Wk gestation)

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

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

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 13-9

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?

While at work?  (Specify type of place) (e) Means of injury 0

23. Signature W. S. Handley, MD (M. D. or other) MD

Address Springfield, Mo. Date signed 11-12-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

5-13-9

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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..... *Ralph H. Thime* .....  
Licensed Embalmer No. *3681* .....  
P. O. Address *Springfield, 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.**