FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 24 1948

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

25873

State File No.

Registration District No. 100 Primary Registration District No. 5383 Registrar's No. 52

1. PLACE OF DEATH:
(a) County DENT
(b) City or town RURAL - GLADDEN TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NONE
(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 MISSOURI (b) County DENT 33
(c) City or town DARIEN 5
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CORA 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 WW
6. (b) Name of husband or wife MARION ANDERSON 6. (c) Age of husband or wife if alive years
7. Birth date of deceased MARCH (Month) 30 (Day) 1872 (Year)

8. AGE: Years 76 Months 4 Days 8 If less than one day hr. min.

9. Birthplace ST JOSEPH (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business

FATHER
12. Name NO RECORD
13. Birthplace NO RECORD (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name NO RECORD
15. Birthplace NO RECORD (City, town, or county) (State or foreign country)

16. (a) Informant Alpha Mooney
(b) Address DARIEN, MO
17. (a) BURIAL (Burial, cremation, or removal): (b) Date thereof 8/10/48 (Month) (Day) (Year)
(c) Place: burial or cremation GREEN FOREST CEM
18. (a) Signature of funeral director Carl T. Spencer
(b) Address SALEM, MISSOURI
19. (a) Aug 11 -48 (Date received by local registrar) (b) M.M. Hart M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 8
year 1948 hour minute M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Drowning
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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) ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED
(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 ... (M.D. or other)
Address Salem Mo Date signed 8/11/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 8-17-48
District Health Office No. 5,
District File Number 8485-20
Date Filed 8-23-48

## 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 Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Ore

**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.**

o. 2B
-3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 100 Primary Registration District No. 3383 Registrar's No. 52

**1. PLACE OF DEATH:**

(a) County Dent

(b) City or town Rural
(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 years, months or days)
In this community

**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 Cora 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 Years

7. Birth date of deceased March 3 1876
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

SUPPLEMENTARY

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March Day 3 Year 1948 hour minute M.

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

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

JB

**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) Suicide
(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 (M. D. or other)
Address Date signed

S-25873 1948