

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36300

Registration District No. 146

Primary Registration District No. 5544

Registrar's No. 68

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural - Burton Twp 3
(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

3. (a) PRINT FULL NAME ORLIE MILTON ANDERSON

3. (b) If veteran, name war None 3. (c) Social Security No. 487-18-6699

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Erma Vogelsang Anderson 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased 4 - 25 - 1910
(Month) (Day) (Year)

8. AGE: Years 38 Months 6 Days 7 If less than one day
hr. _____ min.

9. Birthplace Silver Creek Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation Owner of Anderson Hdwe. Co.

11. Industry or business _____

12. Name Alvin F. Anderson

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

14. Maiden name Amanda Larson

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

16. (a) Informant Mrs. Orlie M. Anderson

(b) Address 707 Range Line, Columbia, Mo.

17. (c) Burial (b) Date thereof 11-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia, Mo.

19. (a) 11-13-1948 (b) Barthelme Fern Larson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
(c) City or town Columbia 2
(If outside city or town limits, write "RURAL")
(d) Street No. 707 Range Line 4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2
year 1948 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 2
1948 to Nov 2 1948
that I last saw him alive on Nov 2 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Compound fracture of both legs. Crushed
Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident (Plane)

(b) Date of occurrence Nov 2, 1948 45

(c) Where did injury occur? Howard County
(City or town) (County)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature W. J. Brown M.D. or other _____

Address Jaycox Mo Date signed 11-8-48

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-15-42

FEB 23 1949

AUG 23 1949

AUG 24 1949

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 _____

Licensed Embalmer No. 4097

P. O. Address. Columbia, 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.