S. No. 300
v. 10-48

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

FILED AUG 21 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26451

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 41 69 Registrar's No. 34

1. PLACE OF DEATH

a. COUNTY: Dekalb

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osborn

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Missouri b. COUNTY: Dekalb

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osborn 6320

d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) R. c. (Last) ANDERSON

4. DATE OF DEATH: (Month) 5 (Day) 29 (Year) 50

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed W

8. DATE OF BIRTH: 9-3-1870

9. AGE (In years last birthday): 79 If under 1 year: Months / Days. If under 1 hr.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): LaSalle Co. Ill. /

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Rasmus Anderson

13b. MOTHER'S MAIDEN NAME: Julia Willanson

14. NAME OF HUSBAND OR WIFE: Louisa Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: L. Wayne Anderson Savannah, MO

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Capillary P[illegible]

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

491X

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March 10, 1945, *to* May 29, 1950, *that I last saw the deceased alive on* May 29, 1950, *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. S. Hall M.D.

23b. ADDRESS: Osborn Mo

23c. DATE SIGNED: May 30/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 5-31-50

24c. NAME OF CEMETERY OR CREMATORY: Ever Green

24d. LOCATION (City, town, or county) (State): Osborn, Mo.

DATE REC'D BY LOCAL REG. 6-3-50

REGISTRAR'S SIGNATURE: Rosa Davidson 82

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Summerfield-Lyon Stewartsville, Mo

(Licensed Embalmer's Statement on Reverse Side)

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 ~ ..... ~ ....., Student Embalmer No. ~ .....,
working under my personal supervision.

Student ~ .....
Student Embalmer

Signed W E Summerfield

Licensed Embalmer No. 3007

P. O. Address Stewartsville, 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.