

FILED AUG 21 1950

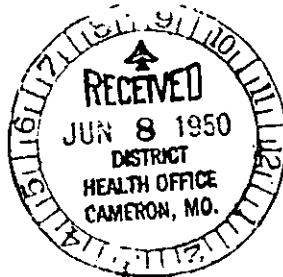
STANDARD CERTIFICATE OF DEATH

State File No. 26451

BIRTH NO.		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 4169		Registrar's No. 34	
1. PLACE OF DEATH a. COUNTY Dekalb				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Dekalb			
b. CITY (If outside corporate limits, write RURAL and give township) Osborn		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) Osborn		b320	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print) JOHN		b. (Middle) R.		c. (Last) ANDERSON		4. DATE OF DEATH (Month) (Day) (Year) 5 29 50	
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH 9-3-1870	
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		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 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Capillary Pneumonia ANTECEDENT CAUSES Morbidity 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1764 10, 1942, to 1774 y 29, 1950, that I last saw the deceased alive on 1774 y 29, 1950, and that death occurred at 3 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Dr. S. H. Hall, M.D.				23b. ADDRESS Osborn, Mo.		23c. DATE SIGNED 1774 y 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 R. Anderson		25. FUNERAL DIRECTOR'S SIGNATURE Summerfield-Lyon		ADDRESS Stewartsville, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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



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. Cunningham

Licensed Embalmer No. 3007

P. O. Address Stewartville, 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.