WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Buchanan

Township ~~Agency~~ or Village Agency or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 80 File No. 19472

Primary Registration District No. 4048 Registered No. 21.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Bessie B. Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

SINGLE X MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: April (Month) 24 (Day), 1918 (Year)

AGE: _____ yrs. 1 mos. 18 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____ 15 TB
(b) General nature of industry, business, or establishment in which employed, (or employer) _____ 15 TB

BIRTHPLACE (City or town, State or foreign country): Agency Mo.

PARENTS

NAME OF FATHER: William Harrison Anderson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Buchanan Co. Mo.

MAIDEN NAME OF MOTHER: Betty Sue Clark

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Buchanan Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Harrison Anderson

(ADDRESS) ~~Fraser~~ Agency Mo

Filed 6/19/18, 191_ R. F. Dowell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 18 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from April 24, 1918, to June 18, 1918, that I last saw her alive on June 17, 1918, and that death occurred, on the date stated above, at 5 a.m. The CAUSE OF DEATH* was as follows:

150

acute exacerbation of congenital hydrocephalus

(Duration) 0 yrs. 1 mos. 18 ds.

Contributory (SECONDARY) Spina bifida

(Duration) 0 yrs. 1 mos. 18 ds.

(Signed) Dr. S. E. Meluney M. D.

June 19, 1918 (Address) Agency Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Frazier Mo.

DATE OF BURIAL: June 19, 1918

UNDERTAKER: H. A. Lullin

ADDRESS: Gower Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 191__

UNDERTAKER | ADDRESS