

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

Do not use this space.

14653

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Trail Primary Registration District No. _____
 City Kansas City (No. Evangelical Hopt) Registered No. 1095 St. 2nd Ward) _____
 2. FULL NAME Charles Anderson
 (a) Residence No. Hay Springs Neb Ward. _____
 (Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U.S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Laura Anderson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 29, 1864
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 | 6 | 9
 8. OCCUPATION OF DECEASED Farmer
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Stockholm (STATE OR COUNTRY) Sweden
 10. NAME OF FATHER Anders Carlson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sweden (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Matilda Peterson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sweden (STATE OR COUNTRY) _____

14. INFORMANT Laura Anderson (Address) Hay Springs Neb
 15. FILED 3/1 1929 M. M. Kerome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 8 1929
 17. I HEREBY CERTIFY, That I attended deceased from April 8 1929 to April 8 1929 that I last saw h. a. a. alive on April 8 1929, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
arteriosclerosis
coronary thromboses
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Uremia
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED At home
 IF NOT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF April 8 29
 WAS THERE AN AUTOPSY? Yes April 8 29
 WHAT TEST CONFIRMED DIAGNOSIS? Hemorrhocult
 (Signed) Jules Fischer M. D.
 (Address) 337 Lathrop Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hay Springs Neb DATE OF BURIAL Apr. 10 1929
 20. UNDERTAKER Jesse R Davidson ADDRESS 3024 1/2 Ave

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.

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... should state ...
... OCCUPATION is very ...
... classified ...

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Towship..... Primary Registration District No..... Registered No. 16 95
City..... (No. Evangelical Hospital St. Ward)

2. FULL NAME

(a) Residence. No. St., Ward. Way Spring, Neb.
(Usual place of abode) (If nonresident give city of town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 11/9 19 29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/8 19 29

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis
coronary thrombosis
(duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY) uremia
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4-8-29

WHAT TEST CONFIRMED DIAGNOSIS? Cystoscopy
Autopsy Nephritis
(Signed) Jules Treacher, M. D.
19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NO RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-14653