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

Do not use this space.
2176 18131

1. PLACE OF DEATH
County Jackson — Registration District No. ..... — File No. .....
Township Kaw — Primary Registration District No. ..... — Registered No. .....
City Kansas City (No. Kansas City Genl Hosp St. ..... Ward)

2. FULL NAME Anderson Chester Miles
(a) Residence. No. Grandview Mo St., ... 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 1929

7. AGE — YEARS: 8 — MONTHS: 4 — DAYS: 21 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): School Boy
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Grandview Mo

PARENTS
10. NAME OF FATHER: John L Anderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Conway Mo.
12. MAIDEN NAME OF MOTHER: Sarah L. Linder
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Record Clerk
(Address) Kansas City Genl Hosp

15. FILED 5/12 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-11 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-4, 1929, to 5-11, 1929 that I last saw her alive on 5-11, 1929, and that death occurred, on the date stated above, at 8:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic cerebro spinal meningitis
18 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 24 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clin & Lab Find.
(Signed) J. H. Jewett M. D.
5-11, 1929 (Address) Supt K.C. Genl Hosp

*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: Belton Mo — DATE OF BURIAL: 5/12 1929

20. UNDERTAKER: O V Mast — ADDRESS: 1915 East 15

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1003 Registered No. 2176

City K. City (No..... St. .....Ward)

2. FULL NAME Anderson, Chester Miles

(a) Residence. No..... St., ...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. 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)
M	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 - 1920

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.
	8	4	21	

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 COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTY)

14. INFORMANT.....
(Address)

15. FILED 5/12, 1929 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5 - 11 - 1929

17. I HEREBY CERTIFY, That I attended deceased from.....
.....19.....to.....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:

.....
.....
.....
..... (duration) .....yrs.....mos.....ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed).....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**

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-18131