

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

Do not use this space.

8986

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Raw Primary Registration District No. 2003
City K. C. Mo. (No. 1115 Brooklyn Ave.)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Emma Louise Anderson

(a) Residence. No. 1115 Brooklyn Ave. St. 9 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 Fe. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4 - 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 8 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(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) Sweden

10. NAME OF FATHER Anderson

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

12. MAIDEN NAME OF MOTHER no record

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

14. INFORMANTS Geo. E. Anderson
(Address) 3441 Wabash Ave. K.C. Mo.

15. FILED 3/28 1930 M. M. Crowe REGISTRAR
Case

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7 1929, to March 28 1930
that I last saw h. ex. alive on March 27 1930 and that death occurred, on the date stated above, at 10³⁵ A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
928
930
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Valvular disease of heart
(duration) 5 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? no
WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) H. C. Anderson, M.D.
3-28, 1930 (Address) 6520 Indep. Ave.

*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 Elmwood DATE OF BURIAL March 31 1930

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K. C. 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.

