

N. B.—Every item of information should be carefully supplied. AGE MUST 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

Do not use this space.

OCT 17 1934

32855

1. PLACE OF DEATH
County Jackson Registration District No. 399
Township Kear Primary Registration District No. 1002
City Kansas City Mo (No. 1320 Pasado) St. _____ Ward _____
2. FULL NAME Geo Anderson
(a) Residence, No. 1320 Pasado 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 mal 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-26-1893
7. AGE YEARS 41 MONTHS 2 DAYS 14 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

OCCUPATION

MOTHER FATHER

17. INFORMANT (ADDRESS) Crowne

18. BURIAL, CREMATION, OR REMOVAL

PLACE Blue Ridge DATE Sept 14 193419. UNDERTAKER (ADDRESS) Called funeral home 1469 E 112 St20. FILED 9-13-34 M. M. Crowne Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/17/34, 19____
22. I HEREBY CERTIFY that the deceased died on _____, 19____
I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, _____ m.

The principal cause of death and related causes of importance were as follows:

Primary disease
Chronic bronchitis
Other contributory causes of importance:
U. A. B. C.

Name of operation _____ Date of _____

What test confirmed diagnosis _____ Was there a _____

23. If death was due to external cause (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) _____, M. D.

(Address) _____

