REC'D AUG 8 1938

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

599

24310
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City K.C. Mo.
(d) Street No. General Hospital #2 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds.
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 1002
Primary Registration District No.
Registered No. 2815

2. PRINT FULL NAME Robert Lucius Anderson 531
(a) Residence, No. 1510 E. 18th St.
(Usual place of abode, if no street address, write county or city)
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10 1889
7. AGE 49 YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hotel Porter
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. Y.

FATHER
13. NAME Willis Anderson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. Y.

MOTHER
15. MAIDEN NAME Nancy Davis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. Y.

17. INFORMANT (ADDRESS) Lillian Anderson 1211 E. 13th St.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Lincoln Cem. DATE 7-14 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) West, Appleton & Jones 1905 Vine St.
20. FILED 7-13 1938 M. M. Crowe, asst. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 10th 1938
22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..... I last saw ..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 9:45 a.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Fred Kelbom
Bronchopneumonia
186a

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 6-30-38
Where did injury occur? Kaw (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Fall down Stairs
Nature of injury ~~K.C.~~ Fractures

24. Was disease or injury in any way related to occupation of deceased? 11
If so, specify .....
(Signed) Russell W. Kerr, M. D.
(Address) K.C.

(Licensed Embalmer's Statement on Reverse Side)

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, C. W. West, or by

Registered Apprentice No. ....., working under my personal supervision.

Signed C. W. West

Licensed Embalmer No. 2510

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.