

JAN 11 1941

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

42794
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township St. Joseph Primary Registration District No. 1001
(c) City St. Joseph (d) Street No. St. Joseph Hospital Registered No. 1270
(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.

2. PRINT FULL NAME

(a) Residence, No. 211 1/2 Mo. Ave St Joseph (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 5 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labourer
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) Tenn.

FATHER 13. NAME Beverly Anderson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT (ADDRESS) Bessie Anderson
211 1/2 Mo. Ave St Joseph

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashtland Cemetery DATE 12-11-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Raymond Mortuary
1602 Menard

20. FILED Dec. 11, 1939 A. J. Mathias
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/7-1939

22. I HEREBY CERTIFY, That I attended deceased from December 4 1939 to Dec 7 1939
I last saw him alive on Dec 7 1939. Death is said to have occurred on the date stated above, at 7:45 p.m.

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

Generalized peritonitis Date of onset 12-3-39
gangrene of ileum 12-6-39
mesenteric thrombosis 12-5-39
Strangulated scrotal hernia 12-4-39

Name of operation Resection of ileum Date of 12-5-39
What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death was due to external causes (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? No
If so, specify _____
(Signed) Cabray Worley, M. D.
(Address) 415 Corby Bldg.

St. Joseph, Mo.

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.

STATE OF MISSOURI - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS - CERTIFICATE OF DEATH - 1939

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

Signed

J. F. Ramsey

Licensed Embalmer No.

4081

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.