

FILED FEB 12 1940 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1854
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 13
 (c) City Fulton (d) Street No. State Hospital #7 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.

2. PRINT FULL NAME Mary Hilda Anderson
 (a) Residence, No. Mt. Sterling, Iowa St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) May 23, 1887

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>52</u>	<u>7</u>	<u>23</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
 9. Industry or business in which work was done, as saw mill, bank, etc. Home
 10. Date deceased last worked at this occupation (month and year) DK 11. Total time (years) spent in this occupation 4 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

FATHER
 13. NAME John Alfred Anderson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

MOTHER
 15. MAIDEN NAME Charlotte Bergquist
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT (ADDRESS) Hosp Records.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Keshoka Mo DATE Jan-17 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) O. Leo Wallace Fulton Mo

20. FILED Jan 17 1940 B. N. Creme Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 16 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb. 11 1939 to Jan 16 1940
 I last saw her alive on Jan 16 1940 Death is said to have occurred on the date stated above, at 5:10 P.M.
 The principal cause of death and related causes of importance were as follows:
Bronchopneumonia Date of onset 4 days

Other contributory causes of importance:
Chronic Pulmonary Tuberculosis & def. def.

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

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No 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) Forrest Thomas, M. D.
 (Address) St. Hosp. No 1

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

Signed.....

Licensed Embalmer No.....

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.