

AUG 25 1940 91

Registration District No.

Primary Registration District No.

Registrar's No.

5810

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Josephine-Heitkamp Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Day
 (Specify whether

In this community _____
years, months or days)3. (a) PRINT FULL NAME Robert A. Anderson 5363. (b) If veteran,
name war *****3. (c) Social Security
No. None4. Sex Male 5. Color or
race White 6. (a) Single, widowed, married,
divorced Married6. (b) Name of husband or wife Sarah Anderson 6. (c) Age of husband or wife if
alive 56 years7. Birth date of deceased September 13 1876
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
63 9 25 hr. min.9. Birthplace Iowa
(City, town, or county) (State or foreign country)10. Usual occupation Laborer11. Industry or business W.P.A.12. Name Daniel Anderson13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Florence Devine
(City, town, or county) (State or foreign country)15. Birthplace England
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Sarah Anderson
(b) Address 1505 A. Hickory St17. (a) Burial (b) Date thereof July 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memorial Park Cemetery18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette Ave19. (a) JUL 10 1940 (b) J. F. Anderson
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
 (c) City or town St. Louis 22
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1505 A. Hickory St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18th day July
year 1940 hour 3:00 minute _____ P. M.21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis Duration _____
with Chronic Interstitial Myocarditis
Contrib: Strepto-Staphylococci
 Due to Cellulitis of the Neck;
Carbuncles on Neck,
 Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations 93C.

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(b) Means of injury _____23. Signature Joseph M. DeLeon (M. D. or other)
Address Deputy Coroner

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 Frank J. Owens

Licensed Embalmer No. 2245

P. O. Address St. Louis, Mo

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.