

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Livingstone
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Chillicothe Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Coak
(c) City or town Chicago
(If outside city or town limits, write "RURAL")
(d) Street No. #148-97-Leaningstone
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Lena Anderson
3. (b) If veteran, name war L
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 13
year 1940 hour 9 minute 30 P.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles A. Anderson
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased April 10 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 9
Aug. 9 - 1940, to Aug. 12 1940
that I last saw her alive on Aug. 12, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death caused by auto mobile wreck Duration _____

8. AGE: Years Months Days If less than one day
71 4 2 hr. - min.

Due to Crushing chest fracture ing her ribs on left side
Due to chest injury & head fracture left clavicle & rib
Other conditions fracture of right humerus
(Include pregnancy within 3 months of death)

9. Birthplace Albion Mich.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Unknown

13. Birthplace Mich.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Mich.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Em Roberts

(b) Address 22 East 31st St New York City

17. (a) Funeral (b) Date thereof Aug 14 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellingtton Kansas near morrsville Mo.

18. (a) Signature of funeral director James J. Gordon
(b) Address Chillicothe Mo.

19. (a) 8-13-40 (b) H. M. Grace M.D.
(Date received local registrar) (Registrator's signature)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Aug 9 - 1940
(c) Where did injury occur? highway 36
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature H. M. Grace (M. D. or other) _____
Address Chillicothe Mo. Date signed 8/13/40

PHYSICIAN
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I 41931

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.

210m

NOV 25 1941

NOV 26 1941

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.....

James D. Gordon....., Registered Apprentice No.....
working under my personal supervision.

Signed *James D. Gordon*.....
Licensed Embalmer No. *1870*.....

P. O. Address *Chillicothe 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29004^X

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 208

Primary Registration District No. 3026

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF BIRTH:

(a) County... *Rippon*

(b) City or town... *Chillicothe*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community..... (Specify whether)

years, months or days

3. (a) PRINTED FULL NAME *Lena Anderson*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *7* 5. Color or race *W*

6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years *71* Months *4* Days *2*

If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month *Aug* day *12* year *1940* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw him..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death *automobile* Duration

Crushing chest fract -

During trip on left

side of chest.

Fract. of left clavicle, and

of left humerus - Accident

Other conditions..... (Indicate presence within 6 months of death)

Major findings: Of operations *occurred on* State Highway #36

Of autopsy *near Moundsville,* Car went off slab + turned over.

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

(a) Accident, suicide, or homicide (specify) *accident*

(b) Date of occurrence *Aug 9 - 1940 (Mon)*

(c) Where did injury occur?..... (City or town) (County) (State) *Higgins 36 Callahan*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *near Moundsville m*

(Specify type of place) While at work?..... (e) Means of injury *m*

23. Signature *H M Bracer* (M. D. or other)

Address *Chillicothe, Mo.* Date signed *10/22/40*

SUPPLEMENTAL

