

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.

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **7380**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Bethesda
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 22 min
(Specify whether)
 In this community 22 min
years, months or days

3. (a) PRINT FULL NAME Died Unknown
 3. (b) If veteran, 1 name war _____
 3. (c) Social Security No. _____

4. Sex male 5. Color or race W
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 21 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 22 min

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

10. Usual occupation _____

11. Industry or business _____
 12. Name Garland M Anderson
 13. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)
 14. Maiden name Edith Marie Kapsner
 15. Birthplace Winnona Austria
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edith Anderson
 (b) Address 3517 Demerette

17. (a) _____ (b) Date thereof 8-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Richter
 (b) Address 3500 Richter

19. (a) SEP 3 1940 (b) _____
(Date received local Registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County _____
 (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 3517 Demerette
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 21
 year 1940 hour 5 minute 30 P.
 21. I hereby certify that I attended the deceased from 7/21/40
 _____, 19____, to 7/21, 1940
 that I last saw him alive on 7/21, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Immaturity
 Due to Basal ganglia lesion
 Due to Abruptio Placentae
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

Major findings:
 Of operations _____
 Of autopsy none

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)
 (a) Means of injury _____

23. Signature W. T. Riley (M. D. or other) _____
 Address 466 Maryland Date signed 7/21/40

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.