

Registration District No. 18-190

Primary Registration District No. 5813

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Rural
(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 _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Newton
(c) City or town Rural
(d) Street No. Seneca
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mary Frances Anderson
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 14 year 1940 hour 2 minute 10 A.M.

4. Sex 7 5. Color or race w
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Charles W. Anderson
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased Nov. 6
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 27, 1940 to Sept 14, 1940
that I last saw him alive on Sept 13, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death apoplexy
Duration _____

8. AGE: Years 78 Months 10 Days 1 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 870

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

10. Usual occupation Housewife

11. Industry or business David Nailorack

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant's own signature Helen P. Reed
(b) Address 2332 Central St.

17. (a) Burial (b) Date thereof Sept 15
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dr. O. F. Brett

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature J. B. Slemmer (Specify type of place) 515 (e) Means of injury _____
Address Seneca, Mo. Date signed 9-14-40

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.

RECEIVED

District Health Officer No. 61

District File Number 1040-2686

Date Filed OCT 10 1940

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

L. H. Blankenship

Licensed Embalmer No. 2397

P. O. Address Monett, 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.