

Registration District No. **713**

Primary Registration District No. **5242 4428**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Pulaski  
 (b) City or town Waynesville Mo.  
(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 2  
(Specify whether  
 In this community 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski  
 (c) City or town Waynesville, Mo.  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th  
 year 1940 hour 5 minute 0 P. M.

21. I hereby certify that I attended the deceased from  
June 30<sup>th</sup>, 1940, to Sept. 5<sup>th</sup>, 1940;  
 that I last saw him alive on Sept. 5<sup>th</sup>, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Intestinal Obstruction

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 24 7 B. D.  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

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) 0  
 (b) Date of occurrence 0  
 (c) Where did injury occur? 0  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? 0 (Specify type of place)  
 (e) Means of injury 0

23. Signature C. G. [Signature] (M. D. or other)  
 Address Waynesville Date signed 9/6/40

3. (a) PRINT FULL NAME Celestia Vandalle Anderson

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Nelson Anderson 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased April 4 1856  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 5 1 hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

11. Industry or business 1

12. Name William Johnson

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

14. Maiden name Mary Cunningham

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

16. (a) Informant's own signature Ora Anderson

(b) Address Waynesville, Mo.

17. (a) Burial (b) Date thereof Sept. 8, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cem.

18. (a) Signature of funeral director J. I. Hoops & Sons

(b) Address Crocker, Mo.

19. (a) 9/6/40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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. 5,

District File Number 10401022

Date Filed \_\_\_\_\_

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

*Paul B. Hooper*

Licensed Embalmer No. 3261

P. O. Address Cracker, 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.