S. No. 2
—9-4-41
5-17-39
I. X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

36083

State File No. 9662

FILED NOV 18 1943

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Missouri Pacific Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 minutes (Specify whether years, months or days)

In this community 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair

(c) City or town E. St. Louis (If outside city or town limits, write "RURAL") NR

(d) Street No. 920 Cutter A ve (If rural, give location) 999 11 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME Albert L. Anderson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 2

5. Color or race Col

6. (a) Single, widowed, married, divorced Child 0

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

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased April 5, 1940 (Month) (Day) (Year)

8. AGE: Years 3 Months 6 Days 27 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name John Anderson
13. Birthplace (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name Gertrude Bender
15. Birthplace (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant John Anderson

(b) Address 920 Cutter, E. St. Louis, Ill

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/4/43 (Month) (Day) (Year)

(c) Place: burial or cremation Ackerman, Mississippi

18. (a) Signature of funeral director R. M. C. Green

(b) Address 3517 Laclede Avenue

19. (a) NOV 3 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 year 1943 hour 4 minute 00 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 Cerebral Spinal Meningitis (Contagious)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Alfred Perry (M. D. or other)

Address Dupont Corona Date signed 11/2/43

(Licensed Embalmer's Statement on Reverse Side)

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. 1173

P. O. Address 3517 Laclede A

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, fact should be so stated above.