

FILED APR 13 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 5655

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Mount Vernon Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 33 days  
(Specify whether  
In this community 33 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis  
(c) City or town Bedalieu  
(If outside city or town limits, write "RURAL")  
(d) Street No. 616 East 12th St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15  
year 1944 hour 3 minute 15 P. M.  
21. I hereby certify that I attended the deceased from February  
12, 1944, to March 15, 1944  
that I last saw her alive on March 15, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration over 9 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 13 ft  
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) \_\_\_\_\_  
(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 plane) \_\_\_\_\_  
While at work? (e) Means of injury 0  
23. Signature E. Colman (M. D. number) \_\_\_\_\_  
Address Mo State Sanatorium Date signed 3-15-44

3. (a) PRINT FULL NAME Dorothy Alice Anderson

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: March 12 1922  
(Month) (Day) (Year)

8. AGE: Years 22 Months 0 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation nil

11. Industry or business \_\_\_\_\_

12. Name Edgar Elwood Anderson

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

14. Maiden name Alice Marie Harbeck

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

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo State San, Mount Vernon Mo

17. (a) Removed (b) Date thereof (Month) (Day) (Year) \_\_\_\_\_

(c) Place: burial or cremation Bedalieu Mo

18. (a) Signature of funeral director Newman

(b) Address Bedalieu Mo

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

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

*Forsyth*

District Health Officer

District File Number 444-424

Date Filed APR 11 1944

**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 *Dwan Ewing*

Licensed Embalmer No. 2847

P.O. Address *Edalia 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 46

Registration District No. 383

Primary Registration District No. 5655

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town St. Vernon Twp.  
(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 \_\_\_\_\_ (years, months or days)

3. (a) PRINT FULL NAME Dorothy Alice Anderson

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 12 1922  
(Month) (Day) (Year)

8. AGE: Years 22 Months 0 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 3/18/44 (b) Andy Crawford  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Pulmonary tuberculosis

Duration over 9 yr

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

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

Other conditions (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) \_\_\_\_\_

(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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL No.

11351