V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

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

#8003
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1944

Registration District No. 378

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32[illegible]
Registrar's No. 9326

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 179 22
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 520 St. Joseph
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Anderson
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex 0 Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ruth
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased Oct (Month) 29 (Day) 1869 (Year)

8. AGE: Years	Months	Days	If less than one day
75	0	1	hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business
FATHER
12. Name Walter Anderson
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name Millie Ward
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
16. (a) Informant Ruth Anderson
(b) Address 520 St. Joseph
17. (c) Cremation (Burial, cremation, or removal) (b) Date thereof 11 (Month) /2 (Day) /44 (Year)
(c) Place: burial or cremation City Cremation
18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Ave.
19. (a) NOV 2 1944 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30th year 1944 hour 9:40 minute P. M.
21. I hereby certify that I attended the deceased from 10/23/44, 19__, to Oct. 30th, 1944, that I last saw him alive on Oct. 30th, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Infarction of lung due to embolus

Due to 93

Due to

Other conditions arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Large heart, Infarcts of the lung.

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 Herbert C. Fritz (M. D. or other)
Address 1515 Lafayette Date signed 10/31/44

(Licensed Embalmer's Statement on Reverse Side)

Not Embalmed

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.

Not Embalmed

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, fact should be so stated above.