S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19840

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 713

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 50 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 3120 St. Joseph Ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas J. Anderson
3. (b) If veteran, name war none
3. (c) Social Security No. 491-09-7665
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Hazel G. Anderson
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased October (Month) 15 (Day) 1876 (Year)

8. AGE: Years 68 Months 8 Days 16 If less than one day hr. min.

9. Birthplace Platte County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation caretaker
11. Industry or business church
FATHER
12. Name Daniel M. Anderson
13. Birthplace unknown (City, town, or county) Kentucky (State or foreign country)
MOTHER
14. Maiden name Alydia N. Carson
15. Birthplace Platte County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Thomas J. Anderson
(b) Address 3120 St. Joseph Ave.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Jo. Mem. Park Cem.
18. (a) Signature of funeral director Hatan Bettole & Bowman
(b) Address 319 South 10th Street,
19. (a) 7/2/45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 year 1945 hour 2 minute 45P M.
21. I hereby certify that I attended the deceased from 6/26, 1945 to 7/1, 1945 that I last saw him alive on 7/1, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death General Hemorage from stomach

Due to unknown

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy yes

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 J. T. Stamey (M. D. or other)
Address 3120 St. Joseph Ave. Date signed 7/1/45

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(Licensed Embalmer's Statement on Reverse Side)

Dr. J. T. Stamey
2624 St. Joseph Ave
2-2043

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 Frank A. Bowman

Licensed Embalmer No. 1710

P. O. Address St Joseph 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.