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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 3 1945

Registration District No. 154

Primary Registration District No. 5575

Registrar's No. 59

1. PLACE OF DEATH: Near Hickman Mills-Mo.

(a) County Jackson

(b) City or town 108th & 71 Highway, Jackson Co.

(c) Name of hospital or institution Funeral Home Washington  
(If not in hospital or institution, write street number or location.)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 12 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town 89th & 71 Highway, Dodson, Missouri  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BUD V. ANDERS

3. (b) If veteran, name war no

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 th  
year 1945 hour 6 minute 00 A.M.

4. Sex Male ( ) 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: November 12 1926  
(Month) (Day) (Year)

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 \_\_\_\_\_ Duration \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>18</u>	<u>6</u>	<u>28</u>	_____hr. _____min.

Due to Skull Fracture

Due to Motor Cycle Traumatism

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

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

10. Usual occupation Filling Station

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Arch Anders

13. Birthplace Linn County Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Danner

15. Birthplace Daviess Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Arch Anders

(b) Address 89th & 71 Highway, Dodson, Missouri

17. (a) Burial (b) Date thereof July 31st 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn ave.

19. (a) 7/30/45 (b) S. Connie B. Hedges  
(Date received local registrar) (Registrar's signature)

Of autopsy no  
Fracture & Impaction

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 7-28-45

(c) Where did injury occur? 108th & 71 Highway, Jackson Co.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
public place

While at work? no (Specify type of place) (e) Means of injury Motor Cycle

23. Signature J. C. ... (M. D. or other) \_\_\_\_\_  
Address 1424 ... Date signed 7-28-45

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

115 (Licensed Embalmer's Statement on Reverse Side)

AUG 20 1945

*Red Bridge & Thompson Rts*

**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.....  
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.**

Registration District No. 154 Primary Registration District No. 0575

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Washington 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 Bud V. Anders

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 7/11 (Month) 12 (Day) 1945 (Year)

8. AGE: Years 18 Months 6 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Riding Station

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

MOTHER FATHER

12. Name Arch Anders

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

14. Maiden name Mary Danner

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

16. (a) Informant Arch Anders

(b) Address 89th & ul Highway, Dodson Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof July 31, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C L Forster

(b) Address 918 Brooklyn Ave K C Mo

19. (a) \_\_\_\_\_ (Date received local registrar)

(b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town 89th & 71 Highway, Dodson Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I autopsied \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

**SUPPLEMENTARY**

SKULL FRACTURE

Due to MOTOR CYCLE TRAUMATISM

Motor-cycle turned over in ditch, killing this deceased

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of operations \_\_\_\_\_

Of autopsy no

History & Inspection

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) Accident

(b) Date of occurrence 7-28-45

(c) Where did injury occur? 108th & 71 Highway, Jackson Co (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place

While at work? no (Specify type of place) (e) Means of injury Motor Cycle

23. Signature James C. Walker, Coroner (M. D. or other)

Address 1424 Professional Bldg Date signed 7-28-45

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

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