

FILED AUG 24 1945
818

Primary Registration District No. 1003

Registrar's No. 7076

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
3837 Wyoming /
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 600

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

(d) Street No. 3837 Wyoming
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Robert J. Anderson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9
year 1945 hour 16 minute 40 P M.

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

6. (b) Name of husband or wife Carrie Anderson 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased July 12, 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan, 1944 to 8-9, 1945
that I last saw him alive on 8-9, 1945
and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>73</u> | <u>0</u> | <u>28</u> | hr. _____ min. |

Immediate cause of death Chronic myocarditis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Dover Tennessee /
(City, town, or county) (State or foreign country)

10. Usual occupation retired meat cutter

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name William Anderson

13. Birthplace Not known Not known 9
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Bates

15. Birthplace Not known Not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Anderson
(b) Address 4252 Neosho

17. (a) burial (b) Date thereof 8/13/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Picker Cem

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? _____

18. (a) Signature of funeral director J L Ziegenhein & Sons
(b) Address 7027 Gravois

19. (a) AUG 12 1945 (b) J. F. Brudick
(Date received at local health office) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury 0

23. Signature Charles C. Drake (M. D. or other) _____
Address 3702 Gravois Date signed 11

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

60
17
9

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..... *G. P. Kudwiel*

Licensed Embalmer No. *3877*

P. O. Address *7027 Travis*

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.