No. 2
—5-43
5-17-39
I X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 30 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38258

Registration District No. 291 Primary Registration District No. 4433 Registrar's No. 65

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

1. PLACE OF DEATH:

(a) County Putnam

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

(c) Name of hospital or institution: ✓ 1 (If not in hospital or institution, write street number or location)

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

In this community 45 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam 86

(c) City or town Unionville 1 (If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME Charles L. Anderson

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hattie Anderson

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased June (Month) 16 (Day) 1871 (Year)

8. AGE: Years 74 Months 3 Days 18 If less than one day hr. min.

9. Birthplace Chariton, Lucas Co (City, town, or county) Iowa 1 (State or foreign country)

10. Usual occupation Produce Dealer Retail

11. Industry or business Retired 10 Months

FATHER
12. Name James Taylor Anderson
13. Birthplace Kentuckey (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Amanda Adeline Carter
15. Birthplace Kentuckey (City, town, or county) (State or foreign country)

16. (a) Informant Mrs C L Anderson

(b) Address Unionville, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct (Month) 7 (Day) 1945 (Year)

(c) Place: burial or cremation Unionville Cemetery

18. (a) Signature of funeral director Comstock Funeral Home

(b) Address Unionville, Mo, By John N. Comstock

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month October day 4 year 1945 hour 5 minutes 30 A.M.

21. I hereby certify that I attended the deceased from June 18, 1945, to Oct 4, 1945 that I last saw him alive on Oct 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic pneumonia	4 days
Due to Metasensing	
Carcinoma of	
Due to prostate	2 years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 5 lb

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 Chas L. Judd (M.D. or other) D.O.

Address Unionville Mo Date signed 10-5-45

1532 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-45-1714
Date Filed NOV 27 1945

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 John N. Comstock

Licensed Embalmer No. 3891

P. O. Address Unionville, 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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1Dec

Registration District No. 291 Primary Registration District No. 4483 Registrar's No. 65

1. PLACE OF DEATH:

(a) County Putnam

(b) City or town Unionville
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Charles L. Anderson

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 M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 16 (Day) (Year)

8. AGE: Years 74 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 10-30-45 (Date received local registrar) (b) Maxwell Dunbar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 16 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 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
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

38258