

S. No. 2  
-12-45  
5-17-39  
I X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10482**  
Registrar's No. **2756**

Registration District No. **318** Primary Registration District No. **1003**

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

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: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day  
(Specify whether \_\_\_\_\_)  
In this community 42 Yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3160 Keokuk  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mr. Charles H. Anderson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Selma Anderson 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased July 8, 1877  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 14th, year 1947 hour 8 minute :00 AM.  
21. I hereby certify that I attended the deceased from Mar 7 1947 to Mar 14 1947  
that I last saw him alive on Mar 8 1947  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Thrombosis  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
69 8 6 hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

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

10. Usual occupation Motorman (Retired)

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

11. Industry or business Public Service Company

12. Name Henry A. Anderson

13. Birthplace Sweden  
(City, town, or county) (State or foreign country)

14. Maiden name Emma

15. Birthplace Sweden  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Selma Anderson

(b) Address 3160 Keokuk

17. (a) Burial (b) Date thereof 3/16/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kings Prairie Cemetery, Monett, Mo.

18. (a) Signature of funeral director Beiderwieden F.H. Inc.  
(b) Address 1936 St. Louis Avenue

19. (a) MAR 15 1947 (b) J. F. Budnick  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_  
23. Signature R. Byland (M. D. or other) \_\_\_\_\_  
Address 3903 Park Ave Date signed J. D. H.

*Emb separate Cert filed*

MAR 15 1947

**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.**