

FILED JUN 3 1947

Registration District No. **294**Primary Registration District No. **3006**Registrar's No. **128**

1. PLACE OF DEATH:

(a) County **Randolph**
 (b) City or town **Moberly, Missouri**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
M. E. Lomick Hosp. **0**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 days**
 (Specify whether
 In this community **Entire life** (Specify whether
 years, months or days)

3. (a) PRINT
FULL NAME**Cora Lee Anderson**3. (b) If veteran,
name war:3. (c) Social Security
No. **500-20-2281**

4. Sex **F** / 5. Color or
race **W**
 6. (b) Name of husband or wife **William Anderson**
 6. (c) Age of husband or wife if
alive **32** years
 7. Birth date of deceased **Feb. 7 1917**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 **3** **21** hr. min.

9. Birthplace **Howard County Missouri**
(City, town, or county) (State or foreign country)10. Usual occupation **grocery clerk**

11. Industry or business

12. Name **William M. Ward**13. Birthplace **Howard Co. Missouri**
(City, town, or county) (State or foreign country)14. Maiden name **Minnie Ellen Boyer**15. Birthplace **Howard Co. Missouri**
(City, town, or county) (State or foreign country)16. (a) Informant **William M. Ward**(b) Address **Centralia, Missouri**17. (a) **Burial** (b) Date thereof **5-30-47**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Columbia, Missouri**18. (a) Signature of funeral director **Bellew Funeral Service**(b) Address **Centralia, Missouri**19. (a) **5-30-47** (b) **Leah Williams-Lowe**
(Date received local registrar) (Registrar's signature) **912**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone** **10**
 (c) City or town **Centralia, Missouri** **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)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **28**
year **1947** hour **3:00** minute **A** M.21. I hereby certify that I attended the deceased from
Sept 1946 19. to **5-28-47** 19.
that I last saw her alive on **5-27-47** 19.
and that death occurred on the date and hour stated above.Immediate cause of death **Eclampsia** DurationDue to **Severe acute pyelonephritis**
NephritisDue to **Pregnancy at term**Other conditions
(include pregnancy within 3 months of death)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) (e) Means of injury

23. Signature **P. O. Baker, M.D.** (M.D. or other)Address **Centralia, Mo.** Date signed **5/29/47**144
ADDITIONAL
SUFFICIENT
INFORMATION
REQUESTED
Underline
cause to
which death
should be
charged sta-
tistically.

RECEIVED
District Health Officer No.
District File Number 6147
Dues Paid JUN - 2 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 Paul J. Ballou

Licensed Embalmer No. 4206

P. O. Address Centralia, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18423

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Manchester
(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 Cora Lee Anderson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ (Unless than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

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

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 28 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Caesarian delivery
Due to _____ on this lady about 7:30 one evening.
Due to Baby born dead.
Other conditions Lady died the following morning
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

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

SUPPLEMENTARY

PLEASE PRINT FULLY - USE UNFOLDING TABS TO MAKE A PERMANENT RECORD

MOTHER FATHER

18423