No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 21 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4003

State File No. 25263

Registrar's No. 6593

WRITE PLAINLY—USING 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 Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Month (Specify whether years, months or days)
In this community

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. 910 Ohio 22
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Gertrude Anderson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Apr (Month) 13 (Day) 1872 (Year)
8. AGE: Years 75 Months 2 Days If less than one day hr. min.
9. Birthplace St. Joseph (City, town, or county) Mo. (State or foreign country)
10. Usual occupation nil
11. Industry or business
MOTHER FATHER
12. Name Hardin Morton
13. Birthplace UNK. (City, town, or county) Mo. (State or foreign country)
14. Maiden name Rachel Jackson
15. Birthplace Jackson (City, town, or county) Miss (State or foreign country)
16. (a) Informant Mary Smith
(b) Address 910 Ohio
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters
18. (a) Signature of funeral director English Und. Co
(b) Address 2931 Lucas Ave
19. (a) JUL 14 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 8 year 1947 hour 9 minute P M.
21. I hereby certify that I attended the deceased from June 5 1947 to July 8 1947
that I last saw her alive on July 8 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Bladder 2 Urinary	Undet.
Due to	
Due to	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Yes

PHYSICIAN
Underline the cause of 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? (Specify) Means of injury 0
23. Signature John B. Clayton (M. D. or other)
Address 2601 N Whittier Date signed 7/10/47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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 Burleson England

Licensed Embalmer No. 4708

P. O. Address 2731 Lucas, Ore

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. 9

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6598

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:
(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 Gertrude Anderson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 13 (Month) (Day) (Year)

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Mo (City, town, or county) (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) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)
4-7-1947

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month April Day 8 year 1947 hour minute M.

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

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

5-25263