

No. 2
12-45
5-17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27311**
Registrar's No. **661**

Registration District No. **128** Primary Registration District No. **2000**

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

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly VA Hospital
(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 **Kansas** (b) County **Sedgwick** **999**
(c) City or town **Wichita** **8**
(If outside city or town limits, write "RURAL")
(d) Street No. **940 Ohio** **2**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **George Anderson**
3. (b) If veteran, name war **World War I**
3. (c) Social Security No. **504-05-2636**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **25**
year **1947** hour **8** minute **50** P.M.
21. I hereby certify that I attended the deceased from
March 3, 19**47**, to **July 25** 19**47**,
that I last saw him alive on **July 25** 19**47**
and that death occurred on the date and hour stated above.

4. Sex **Male** 2
5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Picola**
6. (c) Age of husband or wife if alive **41** years
7. Birth date of deceased **July 5,** **1895**
(Month) (Day) (Year)

Immediate cause of death **Pulmonary tuberculosis** **Duration**
bilateral.

8. AGE: Years Months Days If less than one day
52 - **21** hr. min.

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

9. Birthplace **Longview** **Texas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Sand-blaster**

11. Industry or business.....

MOTHER FATHER { 12. Name **Handy Anderson**
13. Birthplace **Texas**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Bell**
15. Birthplace **Texas**
(City, town, or county) (State or foreign country)

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Clinical Records**

(b) Address **O'Reilly Hoop**

17. (a) **Removal** (b) Date thereof **July 26-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wichita, Kans**

18. (a) Signature of funeral director **Gorman Sharp Funeral Home**

(b) Address **Springfield, Mo**

19. (a) **7-25-47** (b) **WZ Handley MD**
(Date received local registrar) (Registrar's signature)

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)
Means of injury.....

23. Signature **Paul L. Eisele** (M. D. or D.O.)

Address **O'Reilly VA Hospital** Date signed **7-25-47**

OCT 3 1947

SEP 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 *L. G. Schopf*
Licensed Embalmer No. *3862*
P. O. Address *Springfield, 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.