No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 4 1947

Registration District No. 218

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32289
Registrar's No. 8767

1. PLACE OF DEATH:

(a) County
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (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. 1126 Lawn Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John A. Anderson
3. (b) If veteran, name war W.W.#1
3. (c) Social Security No. 493-24-2424
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced D 3
6. (b) Name of husband or wife Unk
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 5, 1890 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
57	4	12	hr. min.

9. Birthplace Sweden 4 (City, town, or county) (State or foreign country)
10. Usual occupation Watchman
11. Industry or business
MOTHER FATHER
12. Name Unk
13. Birthplace Unk 9 (City, town, or county) (State or foreign country)
14. Maiden name Unk
15. Birthplace Unk 4 (City, town, or county) (State or foreign country)
16. (a) Informant John Twiehaus
(b) Address 2143 Esther
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery
18. (a) Signature of funeral director Becker-Hilbert Undt & Rice Co.
(b) Address 3634 Gravois Ave. St. Louis, Mo.
19. (a) SEP 18 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1947 hour 5: minute 50 P.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.

Duration

Immediate cause of death Lobar Pneumonia
Fractured left femur
Contracted when deceased fell in room at 5103 Hamilton
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

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? (e) Means of injury
23. Signature Patrick E. Kaylin M.D. (Coroner)
Address 1300 Clark Date signed 9-18-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

OCT 7 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.....Robert O Wheeler

Licensed Embalmer No. 2178

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.

No. 2B
I—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. OCT

Registration District No. 314 Primary Registration District No. 1003 Registrar's No. 8767

SUPPLEMENTARY

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
In this community years, months or days)

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 John A. 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 Dw

6. (b) Name of husband or wife

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

7. Birth date of deceased May 5 (Month) 1890 (Day) (Year)

8. AGE: Years 57 Months 4 Days 22 If less than one day hr. min.

9. Birthplace (City, town, or county) Sweden (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 17 year 1947 hour 5 minute 50 P.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 Labor Pneumonia Fractured left Femur Suffered when deceased fell in his room at 5103 Manchester Ave; On Sept 14th 1947

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Accident

(b) Date of occurrence Sept 14 1947

(c) Where did injury occur? St Louis Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)

While at work? (e) Means of injury

23. Signature Patrick E Fay (M. D. or other)

Address Dy Ex Date signed 10/9/47

5-32289