

S. No. 29
 D. M. 2-33
 1946-17-39
 1 X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
 1003

State File No. **39382**
 Registrar's No. **11137**

FILED DEC 15 1947 **318**
 Registration District No. _____

Primary Registration District No. _____

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:
2325 Texas Avenue. ↗
 (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 Arvid Anderson
 3. (b) If veteran, name war --
 3. (c) Social Security No. 494-05-8280

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Blanche Anderson
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 2, 1883
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>4</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation Laundry worker

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Blanche Anderson,

(b) Address 2112 S. Jefferson Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1947.
 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Craig Mortuary,
 (b) Address 4468 Washington -8-

19. (a) DEC 5 1947 J. F. Brudbeck
 (Date received from informant) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town Saint Louis 17
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2112 S. Jefferson Ave. 9
 (If rural, give location) 0
 (e) Citizen of foreign country? Yes. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3,
 year 1947 hour 4 minute _____ P. M.
 21. I hereby certify that I attended the deceased from 7-5-47
 _____, 19____, to 11-28-47, 19____;
 that I last saw him alive on 11-28, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chr myocarditis
Hypertension
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy mw

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) _____
 (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 Joseph L. Jones (M. D. or other)
 Address 4065-50th Date signed 12/4/47

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

MOTHER PARTNER

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

Philip M. Lerney

Licensed Embalmer No..... 3281.....

P. O. Address..... Saint Louis, Missouri.....

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.