

No. 2
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5-17-39
X 35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4156**
Registrar's No. **64**

FILED MAR 4 1949

Registration District No. _____ Primary Registration District No. **5760 5160**

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

1. PLACE OF DEATH:

(a) County **CALLAWAY**
(b) City or town **RURAL**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CALWOOD TOWNSHIP
(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 **THOMAS ANDERSON**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

8. AGE: Years **ABOUT 54** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **STANTON MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **INVALID**

11. Industry or business _____

MOTHER FATHER { 12. Name **UNKNOWN**
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 **STATE HOSPITAL RECORDS**
(b) Address **PUNTON, MO**

17. (a) **BURIAL** (b) Date thereof **FEB. 22, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEW HOPS**

18. (a) Signature of funeral director **Glenn Y. Mason**

(b) Address **712 COME FORT ST. MO**

19. (a) **FEB 25 48** (b) **John Morankoff**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Callaway**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Calwood Township**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **20** day **Feb**
year **1948** hour **3** minute **30** M.

21. I hereby certify that I attended the deceased from _____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Occurred fell dead while pushing a wheelbarrow full of wood. Had no physician. Looks like a coronary occlusion.**

Due to: **occlusion**
Due to: **had some heart trouble**

Other conditions: **80 year old tissue but was recent**
Major findings: **treated by a physician**
Of operations: _____
Of autopsy: **945**

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? **hobby night** (Specify type of work) (Date of injury)
fire Marshall

23. Signature **Fullon MO** (M. Registrar)
Address _____ Date signed **2/21/48**

RECEIVED
District Health Officer No. 9,
District File Number
MAR 3 1948
Date Filed

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.....

Theodore Skinner, Jr...... Registered Apprentice No.....

working under my personal supervision.

Signed..... *Glen Y. Maupin*

Licensed Embalmer No..... *2725*

P. O. Address..... *Fulton, 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.