

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Paris Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
613 1/2 main st 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Do not know** years, months or days

3. (a) PRINT FULL NAME **Carl Oscar Anderson**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **495-07-3894**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S O**

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

7. Birth date of deceased **1-14-1890**
(Month) (Day) (Year)

8. AGE: Years **58** Months **7** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **Sweden** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **labor**

11. Industry or business _____

12. Name **Do not know** **9**

13. Birthplace **Do not know** **1**
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace **Do not know** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Curmer office**

(b) Address **12 C Mo**

17. (c) **School** (b) Date thereof **Sept 16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: **W.C. College of Osteopathy & Surgery**

18. (a) Signature of funeral director **Pursantiro Bros.**

(b) Address **12 Corn**

19. (a) **9-15-48** (b) **Steraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Jackson** **48**
(c) City or town **Paris City Mo** **8**
(If outside city or town limits, write "RURAL")
(d) Street No. **613 1/2 main st**
(If rural, give location)
(e) Citizen of foreign country **unknown** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **8**
year **1948** hour **8** minute **45 A.M.**

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

Immediate cause of death **coronary occlusion** Duration _____

Due to **acute rheumat**
Due to _____

Other conditions **938**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **Henry C. Ingwater** 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) (e) Means of injury **3**

23. Signature **James Walker** (M. D. or other) _____

Address **1224 24 July** Date signed **9-2-48**

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

MOTHER FATHER

FEB 17 1949

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 Francis Walter

Licensed Embalmer No. 2744

P. O. Address H C MA

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.