

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or Village \_\_\_\_\_

or City \_\_\_\_\_

Registration District No. 781File No. 28136Primary Registration District No. 1003Registered No. 7439City St. Louis (NO. City Hospital St. 8 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wm. M. Sanders

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	MARITAL STATUS <u>Married</u>
DATE OF BIRTH <u>Oct 22</u> , 18 <u>54</u>	AGE <u>58</u> yrs. <u>9</u> mos. <u>22</u> ds.	

AGE 58 yrs. 9 mos. 22 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work cement worker  
(b) General nature of industry, business, or establishment in which employed (or employer) 5-17

BIRTHPLACE (City or town, State or foreign country) MissouriPARENTS NAME OF FATHER Christ SandersBIRTHPLACE OF FATHER (City or town, State or foreign country) Don't knowMAIDEN NAME OF MOTHER Don't knowBIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Sanders  
(ADDRESS) 3733 JuneyFiled AUG 14 1913 Max Starkloff REGISTRARMISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 12<sup>th</sup>, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred, on the date stated above, 11-11 AMThe CAUSE OF DEATH\* was as follows:  
Shock & Injuria  
(Internal Injuria)  
Stem R. R.  
2.07 M (Duration) yrs. mos. ds.  
Contributory Accident  
(SECONDARY) (Duration) yrs. mos. ds.Signed W. H. Fath M.D.  
8/14, 1913 (Address) Deputy Comm

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RESIDENTS)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence 1117 Robbins AvPLACE OF BURIAL OR REMOVAL Giono DATE OF BURIAL Aug 15, 1913UNDERTAKER Geo L. Plitch ADDRESS 5984 Eastman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

