

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Gasper
Towship Webb
City Webb City (No. 811 W 2nd)

Registration District No. 417
Primary Registration District No. 3021

File No. 27587
Registered No. 122 (Ward)

2. FULL NAME

John William Sanders
(a) Residence No. 811 W 2nd St., _____ Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Nellie G. Sanders

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 4 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
60 | 8 | 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Minister Presb
(b) General nature of industry, business, or establishment in which employed (or employer) Free Salomon
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Wm. W. Sanders

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wabasha Mo

12. MAIDEN NAME OF MOTHER Basia Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Wabasha Mo

14. INFORMANT Mrs. Nellie Sanders (Address) Webb City Mo

15. FILED 9-22-27 R. M. Stormont REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/20 1927

17. I HEREBY CERTIFY That I attended deceased from Aug 31, 1927 to Sept 20, 1927 that I last saw him alive on Sept 20, 1927, and that death occurred, on the date stated above, at 4 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
110
93 A (duration) yrs. mos. ds. 8

CONTRIBUTORY (SECONDARY) Intestinal Infection (duration) yrs. mos. ds. 18

18. WHERE WAS DISEASE CONTRACTED IF NOT IN PLACE OF BIRTH 110

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) T. L. Caldwell M. D.

Sept 27, 1927 (Address) Webb City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Cartersville Cemetery 9/22 1927

20. UNDERTAKER ADDRESS

Steele & Co Webb City

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.

ACT 25 1927

