Williams

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

Do not use this space.

File No. 31643

Registered No. 8983

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. Isolation Hospital St. ..... Ward)

2. FULL NAME HENRY SANDERS

(a) Residence. No. 727 N. SPRING St., 19 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-6-1922

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Claude Sanders

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

12. MAIDEN NAME OF MOTHER Zelma Preston

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

14. INFORMANT Zelma Sanders (Mother)
(Address) 727 N. Spring

15. FILED OCT 8, 1927 Max E. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-7 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Oct-7, 1927 that I last saw h. alive on Oct-7, 1927, and that death occurred, on the date stated above, at 2:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diphtheria, Pharyngeal
10
(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (SECONDARY) Myocarditis, Acute Diphtheritic
(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 727 N. Spring
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) George H. Garrison M.D.
, 19 (Address) Isolation Hospital

*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 McBride Mo. DATE OF BURIAL Oct 8th 1927

20. UNDERTAKER Fred M. Williams ADDRESS 4556 Delmar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.