

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

Do not use this space.

16936

291929

PLACE OF DEATH

County Scottland  
Township Union  
City Flora

Registration District No. 810  
Primary Registration District No. 6056

File No. ....  
Registered No. 28  
St. .... Ward)

2. FULL NAME Wm Lee Sanders

(a) Residence. No. .... 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adelaide Sanders

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 14, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
72 5 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired  
(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) Iowa

10. NAME OF FATHER Joe Sanders

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

12. MAIDEN NAME OF MOTHER Mary Meeks

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

14. INFORMANT (Address) Eva Southmayd  
Memphis 330

15. FILED 4/11, 1929 E E Tamm REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 6 1929

17. I HEREBY CERTIFY, That I attended deceased from Ed. 2, 1929, to April 6, 1929 that I last saw him alive on April 5, 1929, and that death occurred, on the date stated above, at 5u m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Actual suffocation

92A 90W  
95B 90W (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Coronary Aedema (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

18 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. H. Baker, M. D.

4/11, 1929 (Address) Memphis 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 Brook cemetery DATE OF BURIAL 4/8/ 29

20. UNDERTAKER W. K. Payne & Sons ADDRESS Memphis

99  
MAY 29 1929  
71-5-22  
2  
2  
2  
2  
N. E. - Every Certificate of Death is in plain terms, so that it may be properly classified. Exact file number of Certificate

[The main body of the document is extremely faint and illegible. It appears to contain several paragraphs of text, but the characters are too light to be accurately transcribed. There are some faint, scattered marks and what might be the remnants of a signature or stamp on the right side.]

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County, Sevier  
Township, Union  
City, ..... (No. ....) St. .... Ward)

Registration District No. 810  
Primary Registration District No. 605-6

File No. ....  
Registered No. 28

**2. FULL NAME**

Wm Lee Sanders

(a) Residence. No. .... 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 14, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
71 5 22

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration) ..... yrs. .... mos. .... ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) ..... yrs. .... mos. .... ds.  
(c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT..... (Address)

15.

FILED 6/8/29 E E Parrish REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 6 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19..... (Address)

\*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

20. UNDERTAKER ADDRESS

19

WHILE PLAINLY, WITH UNFADING IMPRESSIONS IS A STATE MENT 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. REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-16936