

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

Do not use this space.

7449

**1. PLACE OF DEATH**

County Texas  
Township Rudine  
City Calver (No. \_\_\_\_\_)

Registration District No. 862  
Primary Registration District No. 6135

File No. 7437  
Registered No. 6  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Jesse Berry Sanders

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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 W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1850 May 23

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 8 18

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Blue Bell, Pa.  
(STATE OR COUNTRY) Pa.

10. NAME OF FATHER John Sanders

11. BIRTHPLACE OF FATHER (CITY OR TOWN) North Carolina  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Nancy Berry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N. Carolina  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Jessie M. Sanders  
(Address) Calver Mo.

15. FILED Feb 11 1930 A. N. Dovel REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-11-1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1926 to Feb 11 1930 that I last saw him alive on Jan 1 1930 and that death occurred, on the date stated above, at 4:35 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Hearted Aorties

(duration) 1 yrs. — mos. — ds.

**CONTRIBUTORY (SECONDARY)**

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

D DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

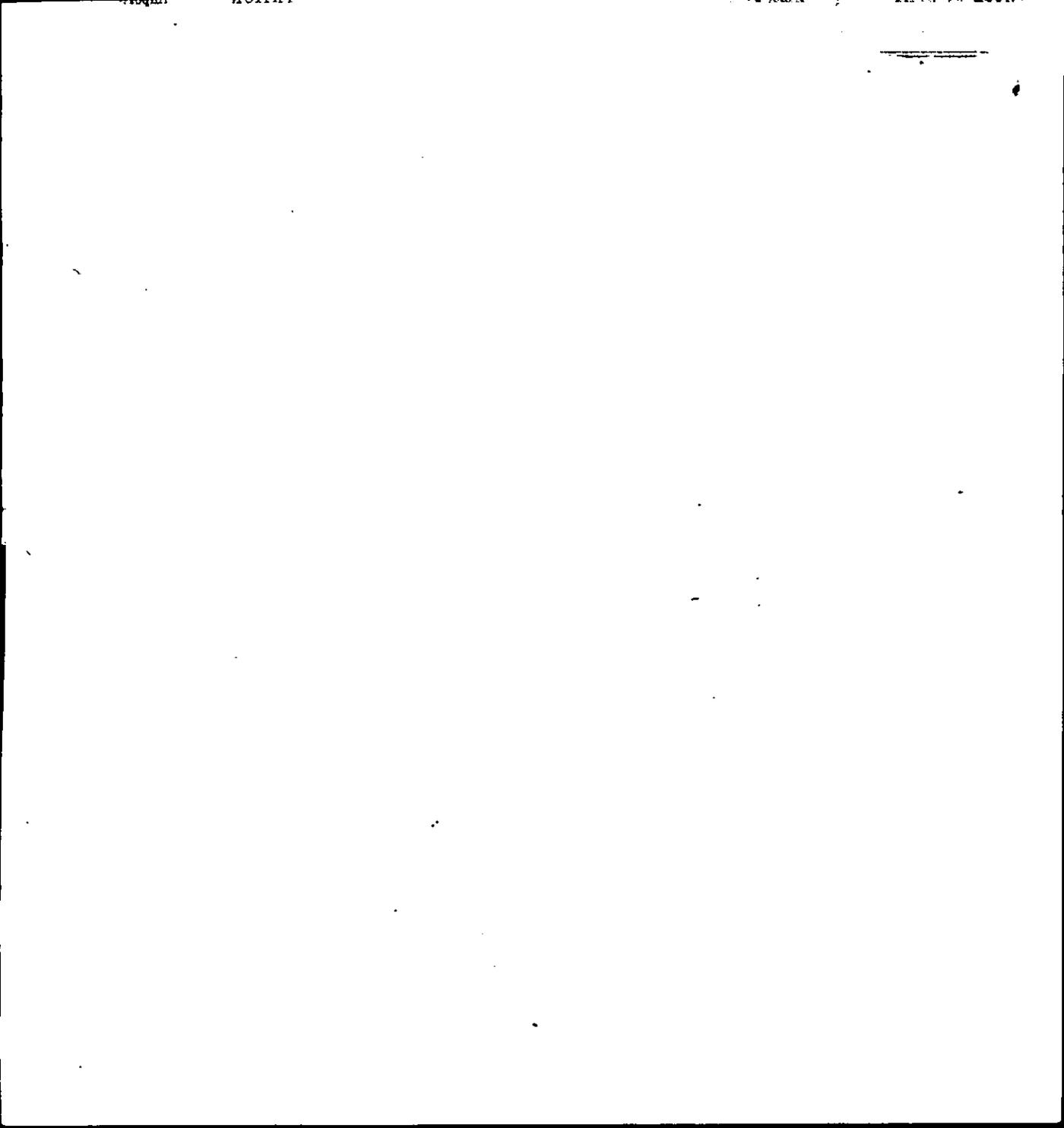
(Signed) J. M. Cook, M. D.

, 19 1930 (Address) Calver 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 Calver Mo. DATE OF BURIAL Feb 11 1930

20. UNDERTAKER Gaylord Willett ADDRESS Calver



**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 Texas Registration District No. 862 File No. \_\_\_\_\_  
 Township Burdine Primary Registration District No. 6135- Registered No. 6  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Jesse Benny 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 M  
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

|        |       |        |      |  |
|--------|-------|--------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|--------|-------|--------|------|--|

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (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) \_\_\_\_\_

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. 4/10/30 and Joel REGISTRAR  
 Filed \_\_\_\_\_ 1930

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/11 1930  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Aspirites  
 \_\_\_\_\_ (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) 2050  
 \_\_\_\_\_ (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) Jon Deaton, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) Carroll Ave

\*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 _____        |

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-7449