

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

Do not use this space.

14869

File No. 4285
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1013
City St. Louis (No. City Hospital)

2. FULL NAME

William Sanders
(a) Residence. No. 2317 Hickory St. 22 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 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 widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF WIFE OF May Sanders

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 25 - 1856

7. AGE YEARS 74 MONTHS 3 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Common Labor
(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) Illinois

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Dr. [Signature]
(Address) City Hospital

15. FILED 1930 Mar 2 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1930

17. I HEREBY CERTIFY, That I attended deceased from April 26 1930 to April 28 1930 that I last saw him alive on April 28 1930 and that death occurred, on the date stated above, at 11:45 am

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
97 (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) General Arterio-sclerosis (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 2317 Hickory
IF NOT AT PLACE OF DEATH, Sw
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? Bay Margulies, M. D.
(Signed) 4/29 1930 (Address) City Hospital

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New St. Marcus Cem. DATE OF BURIAL 4-30 1930

20. UNDERTAKER M^{rs} Laughlin ADDRESS 1631 Mo. av.

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.

Sanders