LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

AUG 26 1930

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

**1 PLACE OF DEATH**

County Carter

Township Carter
or
Village Van Buren
or
City ..... (NO. ....., ..... St.; ..... Ward)

Registration District No. 143 File No. 15561-A

Primary Registration District No. 5205 Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Dority Sanders

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: August (Month) 18 (Day), 1842 (Year)

7 AGE: 87 yrs. 9 mos. 4 ds.

If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer 95
(b) General nature of industry business, or establishment in which employed (or employer): 97 112

9 BIRTHPLACE (City or town, State or foreign country): Johnson Co. Illinois

PARENTS

10 NAME OF FATHER: Lawson Sanders

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Illinois

12 MAIDEN NAME OF MOTHER: Matilda Simmons

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Tennessee Jackson

(Address) Van Buren Mo

15

Filed August 7 1930 J. W. Collou Registrar

**3 MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: May (Month) 22 (Day), 1930 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 10, 1930, to May 22, 1930, that I last saw him alive on May 22, 1930, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

8 Cardiac Insufficiency from Arterio-Sclerosis with general Debility incident to age (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

8 (Signed) J. W. Collou M. D.

May 23 1930 (Address) Van Buren Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Tidolor Cemetery

DATE OF BURIAL: May 23, 1930

20 UNDERTAKER: Oscar Tedder

ADDRESS: Van Buren

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

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.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day, .....hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., .....
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

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

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |