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.

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

Do not use this space.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 29922
Township Kaw — Primary Registration District No. 2 — Registered No. 3727
City Kansas City (No. General Hospital St. Ward)

2. FULL NAME Dewey Sanderson
(a) Residence. No. Missouri Hotel St., Ward. (If nonresident, give city or town and State)
(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: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: About 31 years (YEARS / MONTHS / DAYS) — If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Automobile Driver
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Unemployed

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

PARENTS
10. NAME OF FATHER: James Sanderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT ~~[illegible]~~ Cecil Sanderson
(Address) ~~3611 Mercington~~

15. FILED 9/10, 1930 M. M. Crowe REGISTRAR Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 9, 1930

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:
Encephalitis,
Not Epidemic
78B
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) 70B
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Stanley McHall ~~M.D.~~
9/9, 1930 (Address) Deputy Coroner

*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: Dunwright, Okla ~~Highland Park~~ — DATE OF BURIAL: 9-10-30, 19

20. UNDERTAKER: R. V. Lindsey & Sons, Inc. — ADDRESS: Kans City Mo