

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

Do not use this space.

13. 39515

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Frank Primary Registration District No. _____
City N. E. 2nd (No. 4211 Prospect) St. _____ Ward _____

File No. _____
Registered No. 5188
St. _____ Ward _____

2. FULL NAME

Allan M. Saunders
(a) Residence, No. 4211 Prospect 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 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 Sallie Saunders

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-8-1857

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min. 73 9 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Archite
(c) Name of employer _____

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

10. NAME OF FATHER M. M. Saunders

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

12. MAIDEN NAME OF MOTHER Caroline Poffett

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

14. INFORMANT Mrs. Roy T. D... (Address) 4211 Prospect Ave

15. FILED 7/18/30 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17 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 _____ 1:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
935
97
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Stanley M. Hays, M. D.

1/17, 1930 (Address) 10000 Crowe

*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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Louisville, Ky DATE OF BURIAL Dec-19 1930

22. UNDERTAKER Mrs. C. L. Foster ADDRESS N. E. 2nd

N. H. 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.

