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.

41438

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~ File No. 12123

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis (No. City Hospital St. ..... Ward)

16308 Baby Sanders #4

2. FULL NAME

(a) Residence. No. 1804 N 23rd St., 20 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 27 - 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 13 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) St. Louis
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Robert Sanders

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ~~[illegible]~~ Ky.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Evelyn Henderson

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

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED DEC 28 1930, 19 Max C. Tarlow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1930, to Dec 27, 1930 that I last saw h. alive on Dec 27, 1930, and that death occurred, on the date stated above, at 5:34 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity
Atmt 6½ months
159 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 16 M
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) V. E. Scherman, M. D.
12/28/30 (Address) City Hospital

*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
Anglum Mo	12/28/30 19
20. UNDERTAKER	**ADDRESS**
Arthur J. Donnelly	2039 Wash St

Sanders #1