

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

Do not use this space.

33672

1. PLACE OF DEATH

County Macon Registration District No. 970
 Township Jackson Primary Registration District No. 5702
 City Atlanta St. _____ Ward _____

2. FULL NAME

Robert Sanders
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 67 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-5-1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 11 23

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farm hand
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. and laborer
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Ga

13. NAME James Sanders

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Sarah Holmes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Mrs. Martha Turner
 (ADDRESS) Atlanta Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE McAlister DATE Oct. 30 1933

19. UNDERTAKER Funerary
 (ADDRESS) Atlanta Mo

20. FILED Oct 30 1933 R R Nicoll
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 28, 1933

22. I HEREBY CERTIFY, That I attended deceased from never, 19 , to never, 19 .
 I last saw h. attended him when death is said
 to have occurred on the date stated above, at 7:30 p m.
 The principal cause of death and related causes of importance were as follows:

High blood pressure
caused cerebral
hemorrhage and death
was instant
 102
 Other contributory causes of importance:
82 bad heart
 Date of onset _____

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 .
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no.
 If so, specify _____
 (Signed) W. H. Lynch, Coroner, M. D.
 (Address) Elmer, Mo

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.

NOV 10 1933

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

