

MAR 13 1939

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

4450  
Do not use this space.

791  
1003

Registered No. 1143

1. PLACE OF DEATH
- (a) County ..... Registration District No. ....
- (b) Township ..... Primary Registration District No. ....
- (c) City St. Louis, Mo. (d) Street No. 5245 Washington St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Harry Schley Sanderson
- (a) Residence, No. 5245 Washington St. 12 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Whiteed

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 25, 1869

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

69 1 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Engineer

9. Industry or business in which work was done, as saw mill, bank, etc.

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) Maryland

13. NAME Sanderson

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

15. MAIDEN NAME Unknown

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/3/39, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1938, to Feb. 3, 1939

I last saw h. ~~was~~ alive on Feb. 3, 1939. Death is said to have occurred on the date stated above, at 2.00 P.M.

The principal cause of death and related causes of importance were as follows:

Tubercular Meningitis

Date of onset 1 Day

108

Other contributory causes of importance:

Chronic Myocarditis

Chronic Capillary Endocarditis

Name of operation None Date of .....

What test confirmed diagnosis? Exam 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. No

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) J. P. Bricker, M. D.

(Address) 3115 1/2 Grand St. St. Louis, Mo.

17. INFORMANT Mrs. L. G. Fox  
(ADDRESS) 5245 Washington

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Crematory 2/6/39

19. FUNERAL DIRECTOR (NAME) Edith E. Ambruster  
(ADDRESS) 4234 Manchester

20. FILED FEB 4 1939  
J. P. Bricker  
Local Registrar.

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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Thomas Eynock*

Licensed Embalmer No. *1284*

P. O. Address *St. Louis Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**