

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REV. 3-17-39

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.

Registration District No. 784

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis Co. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Elihu Sander 536

8. (b) If veteran, name war No. _____ 3. (c) Social Security No. _____

4. Sex Male race White 5. Color or race _____

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mildrad 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Oct 31 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

33	10	19	hr. _____ min.
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9. Birthplace Augusta Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Police Officer

11. Industry or business _____

MOTHER FATHER { 12. Name Wm. Sander

13. Birthplace Augusta Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Emma Schrt

15. Birthplace Augusta Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mildred Sander

(b) Address 4112 Shenandoah

17. (a) Burial (b) Date thereof Sept. 21 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Markus

18. (a) Signature of funeral director Benjamin Jurek

(b) Address 1336 St. Louis Ave.

19. (a) SEP 20 1939 (b) A.R. Myer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 4112 Shenandoah
(If rural, give location)

(e) If foreign born, how long in U. S. A. U. S. Born years _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19 year 1939 hour 5 minute 40 AM/PM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Automobile accident. While driving an automobile which left the highway and striking a telegraph pole 9/19/39

Due to Fracture of the skull

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 210 mm

Of autopsy 211

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Sept 19, 1939

(c) Where did injury occur? Rock Hill, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place

23. Signature John O'Connell (M. D. or other) _____

Address Coroner of St. Louis County Mo. Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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.....
Geo. W. [Signature]

Licensed Embalmer No. *3737*

P. O. Address *1936 St. Louis*

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.