

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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**

36653
Do not use this space.

1. PLACE OF DEATH
 (a) County Marion Registration District No. 547
 (b) Township Mason Primary Registration District No. 3079 Registered No. 291
 (c) City Oakwood (d) Street No. 1713 36th Street 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 Sophia Marie Sanders
 (a) Residence, No. 1713 36th Street St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis Sanders

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10, 1952

7. AGE YEARS 87 MONTHS 3 DAYS 3 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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) Hannibal Missouri

FATHER
 13. NAME William D. Waller
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hamburg Germany

MOTHER
 15. MAIDEN NAME Sophia Grush
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hamburg Germany

17. INFORMANT (ADDRESS) Harry Sanders 1713 36th

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet DATE October 15 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smiths' Funeral Home Hannibal Missouri

20. FILED Oct 17 1939 H. C. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 13, 1939

I HEREBY CERTIFY, That I attended deceased from Oct 1 1939 to Oct 13 1939
 I last saw him alive on Oct 13 1939. Death is said to have occurred on the date stated above, at 4:55 A.M.
 The principal cause of death and related causes of importance were as follows:
Dysentery
Senility

Other contributory causes of importance:
Senility

Date of onset 10.1.39

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
 If so, specify _____
 (Signed) H. B. Norton M. D.
Hannibal Mo
 485 (Address)

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.....

.....J. J. Marsh.....L. E. 3932....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Crawford Smith

.....Licensed Embalmer No.....3814.....

.....P. O. Address Hannibal Missouri.....

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.