

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

8328
Do not use this space.

1. PLACE OF DEATH
 (a) County Shelby Registration District No. 830
 (b) Township Shelbina Primary Registration District No. 4503 Registered No. 8
 (c) City Shelbina (d) Street No. _____ 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.
 516 Lucius Lee Sanders
 2. PRINT FULL NAME
 (a) Residence, No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Bertie Cleo Sanders
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dont know - 1869
 7. AGE YEARS 71 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Mechanic
 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) Monroe Co Mo
 FATHER 13. NAME Sidney Sanders
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co Mo
 MOTHER 15. MAIDEN NAME Francis Ruston
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know
 17. INFORMANT M. H. Sanders
 (ADDRESS) Shelbina Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Halliday Mo DATE Feb 25 1940
 19. FUNERAL DIRECTOR (NAME) Shaver
 (ADDRESS) Shelbina Mo
 20. FILED Feb 25 1940 Ruth Joyner
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 24 1940
 22. I HEREBY CERTIFY, That I attended deceased from _____, 1940, to _____, 19____.
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at about 10:30 a. m.
 The principal cause of death and related causes of importance were as follows:
Came to his death from explosion in his home.
Cause of explosion unknown.
 Other contributory causes of importance:
Request deemed unnecessary.
 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) Lucius Lee Sanders (Crown)
 (Address) Shelbina Mo.

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.

FORM-1-12-33 I X14028

1744

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

226-10-1004

RECEIVED

District Health Officer No. 10

District File Number 3-40-662

Date Filed MAR 12 1940

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8328**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **830**

Primary Registration District No. **4502**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Shelby**

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

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Lucius Dee Sanders**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years **71** Months _____ Days _____
If less than one year _____ h. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shelby**

(c) City or town **Shelbina**
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **24**
year **1940** hour _____ minute _____ M.

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 **Came to his death from explosion in his home**

Due to **Cause of explosion unknown**

Due to **known**

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

Major findings: **Inquest deemed necessary**

Of operations **1/4 10 12**

Accidental, as far as we know type of explosion unknown

most parts of body were all that remained

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

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

(b) Date of occurrence _____

(c) Where did injury occur? **HOME**
(City or town) (County) (State)

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

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature **C. W. Mungrove** (M. D. or other) _____

Address **Bethel Mo** Date signed _____

SUPPLEMENTAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged _____

Dear Dr Parker:

In regard to the death of
Mr Sanders, his one room home was
completely destroyed. I think the type of
explosive was Nitro glycerine.

We were unable to find but
a small part of the body, in fact all we
found would not fill a gallon container.

LeWinnegrove. (Crown