

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUL 13 1941

Registration District No. 638

Primary Registration District No. 3028

Registrar's No. 27

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.

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Fredericktown Missouri
(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 2
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME MARTHA LACURIA SANDERS 536
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife N. B. Sanders 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased November 16 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Zion Madison Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business H. S. Cloniger

MOTHER FATHER
12. Name Zion Missouri
18. Birthplace _____
14. Maiden name Cynthia Mc Kinney
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Orla Sanders
(b) Address Fredericktown, Mo. R.F.D. #2

17. (a) Burial (b) Date thereof May 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Pisgah Zion Mo.

18. (a) Signature of funeral director Ed. H. Webb
(b) Address Fredericktown, Mo.
19. (c) May 23, 1940 (Date received local registrar) S. C. S. Cavender
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) City or town _____ (b) County Madison
(c) City or town Rural - Zion
(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 May day 22
year 1940 hour 6:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from May 14 1940
to May 22 1940
that I last saw her alive on May 21 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Copranox Attack
Duration 10 hours

Due to _____
Due to _____

Other conditions Fracture Tibula
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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? _____ (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 S. C. S. Cavender (M. D. or other) _____
Address 122 W. Main St. Date signed 5/23/40

19412

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.....

Myron A. La Pee....., Registered Apprentice No.....
working under my personal supervision.

Signed *Myron A. La Pee*.....
Licensed Embalmer No. *4025*.....

P. O. Address *Fredricktown 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18967

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 77538

Primary Registration District No. 3028

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Fredricks town
(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 _____ (Specify whether)
years, months or days _____

3. (a) PRINT FULL NAME

Martha Lucenia Sanders

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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 56 Months 6 Days 6 If less than one day _____ yr. _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____ (b) County _____
(c) City or town _____ (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month _____ day _____
year _____ hour _____ minute _____ M.

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

Immediate cause of death Coronary
arterial
angina attack
Due to _____
Due to _____

Other conditions fractured fibula
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence May 16 - 1940
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At Home, sick on farm
While at work? _____ (Specify type of place) (e) Manner of injury slipped and fell

23. Signature S.C. Doughter (M. D. or other) _____
Address Fredricks town Mo Date signed _____

SUPPLEMENTAL

S-18957