

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

38874

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH

(a) County Jasper
 (b) City or town Jasper
 (c) Name of hospital or institution Freemant Hospital
 (d) Length of stay: In hospital or institution 7 hours
 In this community 1 day

3. (a) PRINT FULL NAME James Franklin Sanders

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Aug 22 1940
 (Month) (Day) (Year)

8. AGE: Years 0 Months 2 Days 20 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business L

12. Name George Clayton Sanders

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

14. Maiden name Eva Donick

15. Birthplace Washers Co, Okla.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Saracine Mo

(b) Address Clayton Washers

17. (a) Burial (b) Date thereof 11-22-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sarcophag Cometeries

18. (a) Signature of funeral director Walter C. Cole

(b) Address Sarcophag

19. (a) 11-22-40 (b) W. J. Jones
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jasper
 (c) City or town Sarcophag
 (d) Street No. None
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 20
 year 1940 hour 3⁰⁰ minute 0 A. M.

21. I hereby certify that I attended the deceased from Nov 19
 _____, 1940 to Nov 20, 1940
 that I last saw him alive on 11-19-40, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Left lower lobar pneumonia following
 Due to Pertussis

Due to _____
 Other conditions none
 (Include pregnancy within 3 months of death)

Major findings: Of operations none
 Of autopsy none

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature Herman A. LaFore (M. D. or other) MD
 Address 607 Main Jasper Date signed 11-22-40

Duration 4 days
2 wks
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

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 me

....., Registered Apprentice No.
 working under my personal supervision.

Signed.....

Glenn C. Cole

Licensed Embalmer No. 3708

P. O. Address Saco, Me

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.