

FEB 17 1941

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3392

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Maxion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Leveering 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) 0

3. (a) PRINT FULL NAME John W. Sanders  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 490-07-7776

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lula 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 24, 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 3 26 hr. min.

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

10. Usual occupation Machinist

11. Industry or business Hannibal Car Wheel Foundry

12. Name Chester Sanders

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

14. Maiden name Mrs. Marseille

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

16. (a) Informant Lula Sanders

(b) Address Pa 4 Hannibal, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Granovick Burial Park

18. (a) Signature of funeral director James Delaney

(b) Address Hannibal, Mo

19. (a) Jan. 24, 1941 (Date received local registrar) (b) W. C. Fisher (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maxion  
(c) City or town Hannibal, Mo #4  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 1  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19  
year 1941 hour \_\_\_\_\_ minute 10 a.m.  
21. I hereby certify that I attended the deceased from Dec. 28, 1940  
Jan 19, 1941, to \_\_\_\_\_, 1941;  
that I last saw him alive on Jan 19, 1941  
and that death occurred on the date and hour stated above.  
Immediate cause of death Encephalitis

Due to Influenza  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy no

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? 400  
\_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. C. Fisher (M. D. or other) \_\_\_\_\_  
Address Hannibal, Mo Date signed 1-24-41

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

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 Michael J. O'Rourke  
Licensed Embalmer No. 3246  
P. O. Address Hannibal Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**