

**FILED FEB 14, 1941**

Registration District No. \_\_\_\_\_ Primary Registration District No. 5930 Registrar's No. 9

1. PLACE OF DEATH

(a) County Polk

(b) City or town near J. McMillan  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution  
Home west of Bolivar,  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Polk

(c) City or town Bolivar  
(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.

3. (a) PRINT FULL NAME Wangita Joyce Sanders

3. (b) If veteran, name war Child

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24  
year 1941 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan 23 1941  
Jan 24 1941, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex Female 5. Color or race W

6. (a) Single, widowed, married, divorced child

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 17 1939  
(Month) (Day) (Year)

that I last saw her alive on Jan 24 1941, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Meningitis Duration 36 hrs

8. AGE: Years Months Days If less than one day

2 0 7 hr. min.

Due to Influenza 4 days

9. Birthplace Polk Co. MO  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ #  
(Include pregnancy within 3 months of death)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

12. Name Paul Sanders

13. Birthplace Polk Co. MO  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Davis

15. Birthplace Camden Co. MO  
(City, town, or county) (State or foreign country)

Major findings: Of operations None

Of autopsy None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Paul Sanders

(b) Address Bolivar, MO

17. (a) Presbyterian Hill (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

22. If death was due to external causes, fill in the following: No

(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? \_\_\_\_\_

18. (a) Signature of funeral director Whitaker Eason

(b) Address Polina 710

19. (a) Jan 25 (b) J F Roberts 630  
(Interreceived local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify nature of place)

(c) Means of injury \_\_\_\_\_

23. Signature Chas H Brown (M. D. or other) \_\_\_\_\_

Address Fair Play Mo Date signed \_\_\_\_\_

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

RECEIVED

District Health Officer No. 7,

District File Number

2-41-350

Date Filed

2-13-41

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**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, fact should be so stated above.**