

No. 2
4-13-40
-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5789

FILED MAR 14 1941

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 561

48
3
8
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH Jackson

(a) County Kansas City

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

(c) Name of hospital or institution: K.C. General Hospital, No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs. (Specify whether
In this community 25 yrs years, months or days)

3. (a) PRINT FULL NAME Frank Sanders

3. (b) If veteran, name war No 3. (c) Social Security No. 489-05-4916

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife single 6. (c) Age of husband or wife if alive 18 75 years

7. Birth date of deceased April 17th 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>9</u>	<u>13</u>	hr. min.

9. Birthplace Buffalo New York
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Washburn-Crosby Co.

12. Name unknown 9

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

14. Maiden name unknown 9

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

16. (a) Informant Mamie Sterling

(b) Address 510 N. Montgall

17. (a) Burial (b) Date thereof 2/8/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlaw

18. (a) Signature of funeral director Peter S. Geyman

(b) Address R.C.M.

19. (a) 2-9-41 (b) m. m. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 510 N. Montgall
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 25 yrs years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30th
1941 year hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1-30-41, 1941, to 1-30-41, 1941; that I last saw him alive on 1-30-41, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE

Due to _____

Due to _____

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____

Of autopsy Yes

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)

Means of injury _____

23. Signature Dr. J. K. Gen. (M. D. or other) _____
Address Med. Dir. K. C. Gen. Hospital, K. C. Mo. Date dictated _____

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.