

Registration District No. 89

Primary Registration District No. 5134 C

Registrar's No. 263

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Fisk
(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 20 years
years, months or days

3. (a) PRINT FULL NAME John O. Sanders

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sadie Sanders 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased June 8, 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Roy Sanders
(b) Address Fisk, Mo.

17. (a) Burial (b) Date thereof June 29, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ash Hill

18. (a) Signature of funeral director Marshall Shain C. G.
(b) Address Fisk, Missouri

19. (a) 6/27/41 (b) Kate Lutz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler
(c) City or town Fisk
(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 June day 27
year 1941 hour 12 minute 30 a.m.

21. I hereby certify that I attended the deceased from June 20, 1941, to June 27, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis Duration 1 yr.

Due to _____

Due to _____

Other conditions (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 R. F. Farpley (M. D. or other) MD
Address Fisk Date signed June 27, 1941

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

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.

12-10151

JUL 1 1941

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. 34174

P. O. Address. *Golden Bury*

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.