

FILED MAR 23 1942

Registration District No. 836

Primary Registration District No. 12596100

Registrar's No. 5804(7)

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town W O RR
(c) Name of hospital or institution: _____
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

3. (a) PRINT FULL NAME Tom Sanders (Baby)

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

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased: Jan 15 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day 6 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Tom Sanders
13. Birthplace MO
14. Maiden name Eva M Sheppard
15. Birthplace Missouri

16. (a) Informant Tom Sanders
(b) Address Javalle MO
17. (a) Burial (b) Date thereof Jan 11 42
(c) Place: burial or cremation Taylor

18. (a) Signature of funeral director _____
(b) Address Albourn MO
19. (a) 2-11-42 (b) Ms. Cordie Miller
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stoddard
(c) City or town Rural near La Valle
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

10. DATE OF DEATH: Month Jan day 10
year 1942 hour 8 minute 45.0 M.
21. I hereby certify that I attended the deceased from 1-10-42
to 1-10-42, 19____, to _____, 19____;
that I last saw him alive on 1-10-42, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Central Nervous System
Due to Birth injury
Other conditions _____
Major findings: 160c
Of operations _____
Of autopsy _____

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? _____
(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 2
23. Signature W T Gelber (M. D. or other) MD
Address _____ Date signed 1-11-42

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

RECEIVED

District Health Office No. 2,

District File Number 3427306

Date Filed 3/12/42

STATEMENT BY LICENSED EMBALMER

Wm. N. Gilman

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

Wm. N. Gilman

Licensed Embalmer No. 2657

P. O. Address Gilman St

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. -