No. 2
1-13-40
17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 27 1942

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 38256

Registration District No. 333 | Primary Registration District No. 6115 | Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston, Mo.
(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 years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Scott
(c) City or town Sikeston, Mo.
(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.? 0 years.

3. (a) PRINT FULL NAME Eloise Sanders
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W.
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 10 (Day) 1937 (Year)

8. AGE: Years 3 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Scott Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Child
11. Industry or business
FATHER
12. Name Garland Sanders
13. Birthplace Pope (City, town, or county) Ark (State or foreign country)
MOTHER
14. Maiden name Ada Sindle
15. Birthplace Johnson (City, town, or county) Ark (State or foreign country)
16. (a) Informant H. V. Mason
(b) Address Crowder - Mo
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 14 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Carpenter
18. (a) Signature of funeral director Arden Allen
(b) Address McMullin - Mo
19. (a) 11/20/42 (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Nov. 9, 1940 to Nov 14, 1940 that I last saw her alive on Nov 9 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Diphtheria — Duration 2 wks 1 day
Due to: Cardiac Failure
Due to:
Other conditions (Include pregnancy within 3 months of death): No
Major findings:
Of operations: No
Of autopsy: No

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) None
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature M. E. Henderson (M. D. or other)
Address Sikeston Date signed 12-4-40

1010 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1142-1484
Date Filed 11-25-42

## 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.

Not Embalmed
(Under Ellen)

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.**