DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1943

Registration District No. 7

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5959

Primary Registration District No. 4068

Registrar's No. 55

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.

1. PLACE OF DEATH:

(a) County: Callaway

(b) City or town: Mokane (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: 4 years

2. USUAL RESIDENCE OF DEATHS:

(a) State: Missouri (b) County: Callaway

(c) City or town: Mokane (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. c

8. (a) PRINT FULL NAME: James Louis Sanders

8. (b) If veteran, name war: no

8. (c) Social Security No.: no

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Addie Sanders

6. (c) Age of husband or wife if alive: 80 years

7. Birth date of deceased: Oct. (Month) 24 (Day) 1859 (Year)

8. AGE: Years 83 Months 3 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace: Fulton (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: ____

FATHER
12. Name: W. R. Sanders
13. Birthplace: (City, town, or county) DK (State or foreign country)

MOTHER
14. Maiden name: Olivia Sanders
15. Birthplace: (City, town, or county) DK (State or foreign country)

16. (a) Informant's own signature: J. O. Crum
(b) Address: Mokane, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 18, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Hillcrest Cemetery

18. (a) Signature of funeral director: Leo H. Wallace
(b) Address: Fulton, Missouri

19. (a) Feb 18 1943 (Date received local registrar) (b) Josie Moorman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16th year 1943 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov. 22, 1940, to Feb. 16, 1943 that I last saw him alive on Feb. 16, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Valvular Stenosis and Cardiac & bronchial asthma — Duration

Due to: Chronic nephritis

Due to: Malignancy of throat

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations: HSK
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: W. H. Williamson (M. D. or other) MD

Address: Mokane, Mo Date signed: 2-19-43

(Licensed Embalmer's Statement on Reverse Side)

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, ~~only~~ .....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... Elbert E. White

Licensed Embalmer No..... 4168

P. O. Address..... Fulton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.