

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 25

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon 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 _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

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

(d) Street No. South Adams
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Oscar Clarence Sanders

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3 year 1943 hour 10 P minute _____ M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 12 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 24th 1943 to February 3rd 1943 that I last saw him alive on February 23, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration _____

8. AGE: Years Months Days If less than one day

55 21 _____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace Laclede Co Mo (City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) 93%

10. Usual occupation Farming

Major findings: Of operations _____

11. Industry or business _____

12. Name Albert Walker Sanders

Of autopsy _____

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

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

14. Maiden name Asahia Everett

15. Birthplace Laclede Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Jodie Sanders

(b) Address Lebanon Plato R.R

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/43 (Month) (Day) (Year)

(c) Place: burial or cremation White Oak Pond

18. (a) Signature of funeral director W.E. Holman

(b) Address Lebanon Mo

19. (a) 2-9-43 (Date received local registrar) (b) Grace Roper (Registrar's signature)

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 P.G. Saunders (Physician or other)

Address Lebanon Mo Date signed 2-8-43

RECEIVED

District Health Officer No. *Lakside County Health Unit*
District File Number *2-43-19*
Date Filed *3-16-43*

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 *Dorsey M. Howe*
Licensed Embalmer No. *4222*
P. O. Address *Lebanon Mo.*

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.