

NOV 6 1943

State File No. \_\_\_\_\_

Registration District No. 181

Primary Registration District No. 4293

Registrar's No. 45

1. PLACE OF DEATH: *Lincoln*  
(a) County *Lincoln*  
(b) City or town *Elsterry*  
(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 *1*  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State *Mo.* (b) County *Lincoln*  
(c) City or town *Elsterry* *057*  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country *0*

3. (a) PRINT FULL NAME *William Seaton Sanders*

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month *Oct.* day *26*  
year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

21. I hereby certify that I attended the deceased from *October 1, 1943*  
to *October 26, 1943*  
that I last saw *H.M.* alive on *October 25, 1943*  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

Immediate cause of death *Coronary Occlusion* Duration \_\_\_\_\_

7. Birth date of deceased: *Sept 2, 1871*  
(Month) (Day) (Year)

Due to *arterial thrombosis*

8. AGE: Years Months Days If less than one day  
*72 1 24* hr. min.

Due to \_\_\_\_\_

9. Birthplace: *New Hope Mo.*  
(City, town, or county) (State or foreign country)

Other conditions *gangrene of left foot*  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

11. Industry or business *Merchant*

Of autopsy *960*

12. Name *Walter Foley Sanders*

22. If death was due to external causes, fill in the following:

13. Birthplace *V.A.*  
(City, town, or county) (State or foreign country)

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

14. Maiden name *Fannie Knapp*

(b) Date of occurrence \_\_\_\_\_

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

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

16. (a) Informant *W. A. Sanders*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(b) Address *Elsterry Mo.*

While at work \_\_\_\_\_ (Specify type of place)  
(f) Means of injury \_\_\_\_\_

17. (a) *Burial* (b) Date thereof *Oct 28 43*  
(Burial, cremation, or removal) (Month) (Day) (Year)

23. Signature *Dr. Robert H. Williams* (M. D. or other) *2*  
Address *Elsterry, Mo.* Date signed *10/28/43*

(c) Place: burial or cremation *Elsterry, Lincoln*

18. (a) Signature of funeral director *W. A. Sanders*

(b) Address *Elsterry*  
19. (a) *Nov 3 1943* (b) *W. A. Williams*  
(Data received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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 W.D.B. Bradley

Licensed Embalmer No. 3966

P. O. Address E. Perry

**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.**