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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 36875  
Registrar's No. 10501

FILED DEC 9 1943 818  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital,  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 Days  
In this community 40yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Edward Fred Sanders

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

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

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

7. Birth date of deceased December 16, 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>10</u>	<u>26</u>	hr. _____ min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER

12. Name Andrew Sanders

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

14. Maiden name Mary Frick

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

16. (a) Informant Ann Morrison

(b) Address St. Louis City Hospital,  
Max C. Starkloff Memorial

(c) (1) Burial, cremation, or removal Westminster V.  
(2) Date thereof (Month) (Day) (Year) 11/15/43

18. (a) Signature of funeral director [Signature]  
(b) Address 3500 Benton St

19. (a) NOV 30 1943 (Date received here) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
17  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 9225 Montgomery (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ----- 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11,  
year 1943 hour 4:10 minute A. M.

21. I hereby certify that I attended the deceased from October 20, 1943 to November 11, 1943  
that I last saw him alive on November 11, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

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

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 9/2/43

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

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

23. Signature John P. Pope (M. P. number) 11/12/43  
Address 1515 Lafayette Avenue, Date signed \_\_\_\_\_

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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.....

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.**