

Registration District No. 200

Primary Registration District No. 5725

State File No. _____

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Still Hildreth San
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 15 days (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mrs Elizabeth 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 m
6. (b) Name of husband or wife S A Sanders 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 6 1899
(Month) (Day) (Year)

8. AGE: Years 44 Months 11 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Lance Co Ky
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Perry Steele
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name Margery Rouse
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Sam A Sanders

(b) Address Macon Mich

17. (a) removal (b) Date thereof Nov 14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Delbert S Kerner

(b) Address Macon Mich

19. (a) 11/30/43 (b) Gra B. Kunkler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mich (b) County Wayne
(c) City or town Romulus Mich
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1943 hour 5 minute _____ M.

21. I hereby certify that I attended the deceased from Oct. 27
1943, to Nov 11 1943

that I last saw her alive on Nov. 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis several years.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 820

Major findings: Of operations _____

Of autopsy _____

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 Anna L. Mauck (UDA Other)
Address Macon Mo Date signed Nov. 12 1943

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

JAN 6 1944

RECEIVED

District Health Officer No. TU

District File Number 12-43-2060

Date Filed DEC 15 1943

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 Robert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 102

Registration District No. 200 Primary Registration District No. 05725

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

1. PLACE OF DEATH:

(a) County Moacan Hudson Twp.
(b) City or town Still Keldeth Jan.
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(c) Name of hospital or institution
(d) Length of stay: In hospital or institution. (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Elizabeth Sander
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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 6
(Month) (Day) (Year)

8. AGE: Years 44 Months 11 Days 17 (less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 19 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I have seen him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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 _____

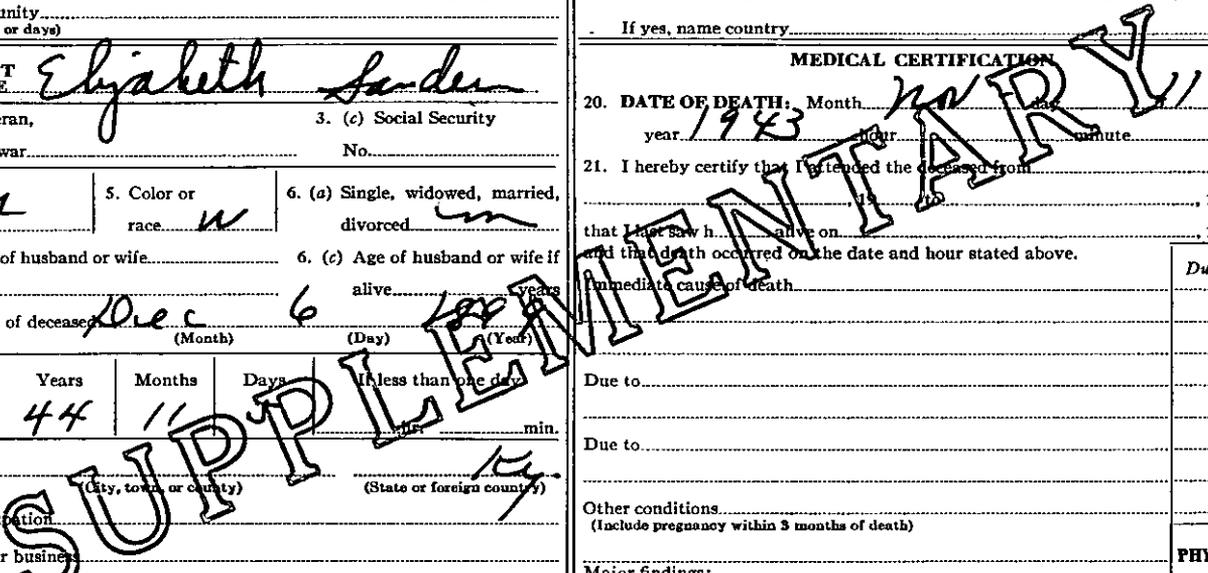
(c) Where did injury occur? _____ (City or town) (County) (State)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____



S-42945