

FILED JUL 26 1944
 818

Primary Registration District No. 1003

Registrar's No. 6330

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Illinois (b) County Union
 (c) City or town Cobden
(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 _____

3. (a) PRINT FULL NAME Flora Sanders
 (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 17th
 year 1944 hour 9 minute 25 A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Robert Wm. Sanders 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased June 15th 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 12 - 1944 to July 17 - 1944
 that I last saw her alive on July 17, 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 7 Days 2 If less than one day _____ hr. _____ min.

Immediate cause of death:
Myocardial infarction
Chronic Intestinal Intussusception
Chronic Intestinal Neoplasm
Post-operative Hernia
 Other conditions (Include pregnancy within 3 months of death) _____
 Duration
1 yr
5 yrs
5 yrs
1 yr

9. Birthplace Williamson Illinois
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Major findings:
 Of operations Intestinal Obstruction - Partial
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 12. Name Unknown Trout
 13. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown Unknown
 15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. R. L. Sanders
 (b) Address 4257a DeTonty St.
 17. (a) Removal (b) Date thereof July 18 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Cobden Illinois
 18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Ave
 19. (a) JUL 17 1944 (b) J. F. Brudeck
(Date received local registrar) (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?
(Specify type of place)
 While at work _____ (Specify type of place) (e) Means of injury _____
 23. Signature Charles B. Shutt (M. D. or other) _____
 Address 720 N. 4th Date signed 7/17/44

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

MOTHER FATHER

Ch - 2546

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.....

John Agnoski

Licensed Embalmer No.....

2398

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.