

FILED AUG 10 1944

Registration District No. **31944**

Primary Registration District No. **4475**

Registrar's No. **134**

1. PLACE OF DEATH:

(a) County **SALINE**
(b) City or town **MALTA Bend**
(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 **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **SALINE 97**
(c) City or town **MARSHALL MALTA Bend**
(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 **FANNIE SAUNDERS**

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

4. Sex **3 FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **2 Wid.**

6. (b) Name of husband or wife **TOM SAUNDERS** 6. (c) Age of husband or wife if alive **3** years

7. Birth date of deceased **APRIL 3 1862**
(Month) (Day) (Year)

8. AGE: Years **82** Months **2** Days **28** If less than one day hr. min.

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

10. Usual occupation **House Keeper**

11. Industry or business

12. Name **CRAWFORD**

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

14. Maiden name **Unknown - SLAVE**

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

16. (a) Informant **Thelma Divers**

(b) Address **KANSAS City, KANS**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **July 2 44**
(Month) (Day) (Year)

(c) Place: burial or cremation **MALTA Bend MO**

18. (a) Signature of funeral director **DON SHORT**

(b) Address **MARSHALL**

19. (a) **7-13-44** (Date received local registrar) (b) **Mo. Towestbrook** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30** year **1944** hour **5** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **6-26th** 19**44** to **6-30** 19**44**
that I last saw her alive on **6-28th** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis chronic** Duration **3**

Due to

Due to

Other conditions **Arteriosclerosis** (Include pregnancy within 3 months of death)

Major findings: Of operations **93d** 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) (c) Means of injury

23. Signature **Geo A. Telling** (M. D. or other) Address **Waverly MO** Date signed **7-6-44**

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

97
80

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-9-47

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 *Don Short*

Licensed Embalmer No. *3757*

P. O. Address *Marshall 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.