

S. No. 2
 OM-2-43
 v. 5-17-39
 P-I X35897

30398

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 FILED OCT 11 1944

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. 228

Registration District No. 1

Primary Registration District No. 5003

1. PLACE OF DEATH:
 (a) County Adair
 (b) City or town Rural - Morrow Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
near Stahl, Mo
 (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 Adair
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Address: Stahl, Mo
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME John Will Sanders
 3. (b) If veteran, name war no 3. (c) Social Security No. no

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 8 day 31
 year 1944 hour 6 minute P.M.

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife Cinderella Sanders 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased: (Month) 12 (Day) 20 (Year) 1861

21. I hereby certify that I attended the deceased from Aug 22
1944, 19 , to Aug 31 1944
 that I last saw him alive on Aug 30 1944
 and that death occurred on the date and hour stated above.

AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>11</u>	hr. _____ min. _____

Immediate cause of death Cerebral Hemorrhage Duration 9 days
 Due to Stroke Nephritis 5 years
 Due to _____

9. Birthplace Shibley Point, Mo
 (City, town, or county) (State or foreign country)
 10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)
 Major findings: 1312
 Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name John H Sanders
 13. Birthplace Ky
 (City, town, or county) (State or foreign country)
 14. Maiden name Frances Jane Scorer
 15. Birthplace Halls Co Mo
 (City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Artie Hatfield
 (b) Address Stahl, Mo

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?

17. (a) Burial (b) Date thereof Sept 2 - 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Green Grove

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

18. (a) Signature of funeral director Green E. Kent & Son
 (b) Address Green City, Mo
 19. (a) 9-7-44 (b) Mrs. J. L. Wagnor
 (Date received local registrar) (Registrar's signature)

23. Signature H. A. Garrison (M. D. or other)
 Address Springer, Mo Date signed 9-1-44

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 10
District File Number 10-44-1699
Date Filed OCT-1-6-1944

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 Glenn E Keut

Licensed Embalmer No. 1769

P. O. Address Green City, 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.