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FILED JAN 10 1945  
Registration District No. 280

Primary Registration District No. 6225

State File No. \_\_\_\_\_

Registrar's No. 209

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution State Hospital # 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no 6 days  
In this community no 6 days  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4015 Maple  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EMILIE E. SANDER

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 17  
year 1944 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from Nov 19 1944 to Dec 17 1944  
that I last saw her alive on Dec 16 1944  
and that death occurred on the date and hour stated above.

4. Sex Female 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 \_\_\_\_\_ years

7. Birth date of deceased: June 10 1877  
(Month) (Day) (Year)

Immediate cause of death apoplexy Duration 2 days

8. AGE: Years 77 Months 6 Days 7 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \$30

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

Other conditions Senile Dementia  
(Include pregnancy within 3 months of death)

9. Birthplace St. Louis Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Employer

11. Industry or business none

Major findings: no

Of operations no

Of autopsy no

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

MOTHER FATHER

12. Name Tred Kappenberg

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

14. Maiden name Anna Salf

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

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? \_\_\_\_\_

16. (a) Informant Myra Schach

(b) Address St. Louis Mo

17. (a) Removal (b) Date thereof 12-17-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau Mo

18. (a) Signature of funeral director Reichinger, Fun. Dir.  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

(b) Address St. Louis Mo

23. Signature Edward M. Bewick (M.D. or other) \_\_\_\_\_  
Address St. Louis Mo Date signed 12/17/44

18. (a) Signature of funeral director Reichinger, Fun. Dir.

(b) Address St. Louis Mo

19. (a) 12-17-44 (b) Edward M. Bewick  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

Embalmer Officer No. 7,

License No. 12-44-1448

Date Filed 1-8-45

**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 Marsh Eichenizer

Licensed Embalmer No. 2626

P. O. Address Nevada, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 42321  
Registrar's No. 209Registration District No. 360Primary Registration District No. 6225

## 1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Rural Washington  
(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 \_\_\_\_\_  
(Specify whetherIn this community \_\_\_\_\_  
years, months or days)3. (a) PRINT  
FULL NAMEEmil E Sanders3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F5. Color White  
race6. (a) Single, widowed, married,  
divorced S

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased

June 10  
(Month) (Day) (Year)

8. AGE:

Years 72 Months 6 Days 4  
If less than one day \_\_\_\_\_ min.

9. Birthplace

(City, town, or county) (State or foreign country) Mo

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

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) \_\_\_\_\_

(Date received local registrar)

(b) Hazel B. Bewick  
(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 \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw 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 sta-  
tistically.

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 \_\_\_\_\_

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

SUPPLEMENTARY

S-42321 1944