

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Luke's Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Albert C. Sanderson

3. (b) If veteran, name war World War # 1 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillie Sanderson 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased April 28 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>50</u>	<u>8</u>	<u>8</u>	_____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Albert E. Sanderson

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

14. Maiden name Mattie Belle Lake

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

16. (a) Informant Mrs. A.C. Sanderson

(b) Address Williamsville, Mo.

17. (a) Burial (b) Date thereof 1-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Piedmont, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 9 (b) J. F. Bredeck
(Date received local registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne
(c) City or town Williamsville
(If outside city or town limits, write "RURAL") NB
(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 1 day 6
year 45 hour 10³⁰ minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec. 30, 1944 to Jan. 6, 1945
that I last saw him alive on Jan. 6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic leukemia (Ataxemic type) (Chronic) Duration 6 mo.

Due to _____

Due to _____

Other conditions Lobar pneumonia 36 hr.
(Include pregnancy within 3 months of death)

Major findings: Pneumonia enlarged liver, spleen & lymph nodes
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) Means of injury _____

23. Signature Geo. W. Stiles (M.D. number) _____
Address 5720 Washington Blvd. Date signed 1-6-45

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

MOTHER FATHER

MAR 2 1945
972

972

JAN 22 1945

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 *Albert G. Hoffer*

Licensed Embalmer No. *2971*

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.