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DM—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4779

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1265

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: Barnes Hospital, O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or Institution 9 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1816 E. 26th St.
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Walter Jasper Sanders

3. (b) If veteran, name war None

3. (c) Social Security No. 078-05-1720

4. Sex Male O

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bonnie Sanders

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March (Month) 1 (Day) 1887 (Year)

8. AGE:

Years	Months	Days	If less than one day
57	11	6	hr. min.

9. Birthplace Henry County (City, town, or county) Missouri O (State or foreign country)

10. Usual occupation Switchman

11. Industry or business

FATHER
12. Name William Sanders
13. Birthplace Unknown (City, town, or county) Missouri O (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Bonnie Sanders
(b) Address Kansas City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) FEB 8 1945 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 7 year 1945 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from January 29, 1945, to February 7, 1945, that I last saw him alive on February 7, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Cystic disease of the lung, non-tuberculosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Pneumonectomy - cystic disease of the lung

Of autopsy none

Duration

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) (e) Means of injury

23. Signature F. R. Bradley (M. D. or other)

Address Barnes Hospital Date signed 2/7/45

(Licensed Embalmer's Statement on Reverse Side)

FEB 23 1945

1265

APR 20 1945

1265

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 H. Thompson

Licensed Embalmer No. 1869

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.