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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr Robert Williams

State File No. C4C4

Primary Registration District No. 2000

Registrar's No. 160

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1912 E. Brower
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community 6 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 1912 E. Brower
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sanford Ellen Sanders

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John Harrison Sanders

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

7. Birth date of deceased July (Month) 16, (Day) 1877 (Year)

8. AGE: Years 68 Months 7 Days 9 If less than one day hr. min.

9. Birthplace Texas County, 6 (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In Home

FATHER
12. Name Amos Owen
13. Birthplace Gainesville (City, town, or county) Georgia (State or foreign country)

MOTHER
14. Maiden name Nellie Hunter
15. Birthplace Wright County, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant John Harrison Sanders
(b) Address Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ 27/45 (Month) (Day) (Year)
(c) Place: burial or cremation Cabool, Missouri

18. (a) Signature of funeral director Elliot Funeral Home
(b) Address Cabool, Missouri

19. (a) 2-26-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25th, year 1945 hour 10:45 minute A. M.

21. I hereby certify that I attended the deceased from Feby 18, 1945 to Feby 25, 1945 that I last saw her alive on Feby 25, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease

Due to

Due to

Other conditions no
(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

Duration: Several years

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) no

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Robert T Williams (M. D. or other)

Address Springfield Mo Date signed 2-26-45

(Licensed Embalmer's Statement on Reverse Side)

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 L. A. Rood

Licensed Embalmer No. 3044

P. O. Address Springfield 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.