

S. No. 2
M-2-43
5-17-39
P-1 X35897

#38789
DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED APR 27 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11720

State File No. _____
Registrar's No. **3421**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 mos-3 days**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **5115 North Broadway** (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Sarah Sanders**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

20. MEDICAL CERTIFICATION
DATE OF DEATH: Month **April** day **15th**
year **1945** hour **11:50** minute **P.** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **John A. Sanders** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May 18, 1875**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **2/10/45** to **3/15/45** 19____
that I last saw her alive on **3/15/45** 19____
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 **10** **28** hr. min.

Immediate cause of death
General paresis
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) **30**

9. Birthplace **Florissant Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **At home**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name **John Peek**
13. Birthplace **Unknown Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Washaw**
15. Birthplace **Unknown Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ernest J. Von Leffern**
(b) Address **5115 North Broadway**
17. (a) **Burial** (b) Date thereof **4/19/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peters Cemetery**

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? _____

18. (a) Signature of funeral director **Math Hermann & Son**
(b) Address **APP 2461 East Fair Ave**
1943
19. (a) **APP 17 1945** (b) **J. F. Bruck**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **Ellie S. Rippe** (M, D, or other) _____
Address **1515 Lafayette** Date signed **4/16/45**

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

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 *Harold H Burnley*.....

Licensed Embalmer No. *42020*.....

P. O. Address *St. Louis, 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.