

**FILED JUN 2 1945**  
Registration District No. 298

Primary Registration District No. 6023

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Ray Co.  
(b) City or town Rural Knobloch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Carrie K. Sanders

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Dave Sanders 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 4 - 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 7 10 hr. min.

9. Birthplace Jackson Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper for son

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hanibal LeShuer  
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Ryge Cartmell  
15. Birthplace Jackson Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant James Sanders  
(b) Address Palo Mo

17. (a) Burial (b) Date thereof 5-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cemetery  
18. (a) Signature of funeral director Alspaugh  
(b) Address Palo Mo.

19. (a) 5-16-45 (b) W.A. Black  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14  
year 1945 hour 7 minute 10 P M.

21. I hereby certify that I attended the deceased from May 7, 1945  
to May 14, 1945  
that I last saw her alive on May 13, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Expansion Duration 4 days  
Due to Arricular Fibrillation do not know

Due to Mitral Stenosis old

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy 950  
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? \_\_\_\_\_

(Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W.A. Black (M. D. \_\_\_\_\_)  
Address Palo Mo Date signed 5-12-45

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6/7/45

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.....

Licensed Embalmer No.....

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.