

DEPARTMENT OF COMMERCE
BUREAU OF THE CENTRAL REGISTER
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28073

State File No.

Registrar's No. 105

FILED SEP 14 1945
71668

Registration District No. 245

Primary Registration District No. 5887

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Paul W. Bentons Hosp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ASF REGIONAL HOSPITAL, Camp Crowder MO.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community 53 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Stella Mo R, # 2
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

3. (a) PRINT WALTER CRAVENS SANDERS
FULL NAME

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife KATIE SANDERS 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased March 15th, 1891
(Month) (Day) (Year)

8. AGE: Years 53 Months 6 Days 15 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name J. R. Sanders
13. Birthplace IND.
(City, town, or county) (State or foreign country)
14. Maiden name Martha Sanders FRANCISCO
ARK.
15. Birthplace ARK.
(City, town, or county) (State or foreign country)

16. (a) Informant Katie Sanders

(b) Address Stella Mo, R, # 2

17. (a) BURIAL (b) Date thereof Oct. 3, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Owsley Cemetery

18. (a) Signature of funeral director Charles Williams
Goodman MO.

19. (a) Sept. 13, 1945 (b) Melvin C. Bowman
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month OCT day 1st,
year 1944 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from 12 AM
October 1, 1944, to 9:48 PM October 1, 1944;
that I last saw him alive on October 1, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death
Injury of spinal cord, with consequent
traumatic transverse myelitis
at level of C6.

Due to truck accident - N.H.

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
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) accident 73

(b) Date of occurrence 27 Sept. 1944

(c) Where did injury occur? Neosho, Newton, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on Neosho + Elm Spring Road

While at work? (Specify type of place)
(e) Means of injury struck by truck

23. Signature Living K. Schwartz (M. D. or other) N.H. M.C.

Address ASF Regional Hosp., Camp Crowder, Mo. Date signed 1 Oct. 1944

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

MOTHER FATHER

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

Merrill Pickett

Licensed Embalmer No.

4166

P. O. Address

Godman, Va.

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.

Registration District No. 245 Primary Registration District No. 5837

1. PLACE OF DEATH:
 (a) County Newton
 (b) City or town Rural, Ma Benton Imp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Walter G. Sanders
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased mar
(Month) (Day) (Year)
 8. AGE: Years 53 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) Melvin C. Bowman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (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 _____ Day _____ Year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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 _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

S-28073