No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31309

Registration District No. 300 Primary Registration District No. 6029 Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds

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

(c) Name of hospital or institution: 5 Mile South of Ruble
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community almost all life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Reynolds 90

(c) City or town Ruble Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Peter Sanders

3. (b) If veteran, name war 0

3. (c) Social Security No. 0

4. Sex M O

5. Color or race W

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

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

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Apr (Month) 8 (Day) 1863 (Year)

8. AGE: Years 82 Months 4 Days 29 If less than one day ..... hr. ..... min.

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

10. Usual occupation farmer

11. Industry or business

FATHER
12. Name Lawson Sanders
13. Birthplace (City, town, or county) Tenn (State or foreign country)

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

16. (a) Informant Clara Sanders
(b) Address Ruble Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation Yount Memorial

18. (a) Signature of funeral director Seaton Pewitt
(b) Address Van Buren Mo

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6
year 1945 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from ....., 1943, to ~~April~~ 9-6, 1945
that I last saw him alive on 9-6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency, Brights disease and hypertrophy of prostate.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Frank J. Rucinski (M.D. or other) D.O.
Address Van Buren, Mo Date signed 9-9-45

1136 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 1045 403
Date Filed 10-6-45

921

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 Seaton Pevitt

Licensed Embalmer No. 2287

P. O. Address Van Buren M

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.

No. 2B
-8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 300 Primary Registration District No. 6029 Registrar's No. a

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

1. PLACE OF DEATH:

(a) County Reynolds

(b) City or town Ruble Rural Logan Twp
(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)

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

3. (a) PRINT FULL NAME Peter 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Apr. (Month) 8 (Day) 1856 (Year)

8. AGE: Years 82 Months 4 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) Ill. (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to chronic Nephritis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 131b	

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)
(b) 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 Frank J Rucinski (M. D. or other) D.O.
Address Van Buren, Mo. Date signed

SUPPLEMENTARY

31309