

FILED NOV 23 1945 STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. 9858

Registration District No. 318 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital
(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 Missouri (b) County Macon
(c) City or town Macon
(If outside city or town limits, write "RURAL")
(d) Street No. 417 N. Rubey
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Robert L. Sanford

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Irma Sanford 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased November 26 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 11 12 hr. _____ min.

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

10. Usual occupation Metalurgist

11. Industry or business _____

12. Name John W. Sanford

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Augusta Knight

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

16. (a) Informant Mrs. Irma Sanford

(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 11-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macon, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 14 1945 (b) J. F. Bredeek
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
year 1945 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from October 14, 1945, to November 8, 1945;
that I last saw him alive on November 8, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia - Bilat. since 4/45
Duration _____

Due to Chronic Myocardial Disease 1 yr

Due to Hypertension (?)

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____

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

23. Signature Truman S. Arabe (M. D. or other) _____

Address 114 N. Taylor Date signed 12/20/45

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

MOTHER FATHER

60
17
9

61
NR-2
3

9858

9858

2001

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

Robert G. Kopper

..... Licensed Embalmer No.....

2971

..... 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.