

FILED DEC 28 1945 STANDARD CERTIFICATE OF DEATH

State File No. 42504

Registration District No. 3/7

Primary Registration District No. 6076

Registrar's No. 2848

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1730 days
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Lee Albert Sanders

3. (b) If veteran, name war -
3. (c) Social Security No. 486-16-1227

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

6. (b) Name of husband or wife Leona Lawson Sanders
6. (c) Age of husband or wife if alive - years

7. Birth date of deceased: 9 (Month) 29 (Day) 1908 (Year)

8. AGE: Years 37 Months 2 Days 16 If less than one day
hr. min.

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

10. Usual occupation Orderly

MOTHER FATHER

12. Name Leondus Sanders Missouri

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

14. Maiden name Hallie Harris

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

16. (a) Informant Hospital Records

(b) Address Koch Hospital, Koch, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45
(Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) 12-18-45 (Date received local registrar) (b) E. M. Garrison (Registrar's signature) MS

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") 17
(d) Street No. 2109 North 13th St. (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 15 year 1945 hour 6 minute 44 A. M.

21. I hereby certify that I attended the deceased from 3-21, 1941 to 12-15, 1945
that I last saw him alive on 12-15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 5 yrs.

Due to 13 1/2
Due to

Other conditions (Include pregnancy within 3 months of death)

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?

While at work? (Specify type of place) (g) Months of injury 0
23. Signature Leinhold Englemann M.D. Address Koch Hosp. Date signed 12/17/45

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..... *John P. Buchholz*

Licensed Embalmer No..... *1674*

P. O. Address..... *2223 St. Louis Ave*

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.