No. 2
—2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Calloway

5278

State File No.

FILED MAR 18 1946

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 113

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: Spfd. Baptist Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether

In this community 1 Day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright 114

(c) City or town Mt. Grove (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 Beulah A. Sanders

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William Albert Sanders

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Sept. (Month) 29 (Day) 1890 (Year)

8. AGE: Years 55 Months 4 Days 3 If less than one day hr. min.

9. Birthplace Alto Pass (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Lon Sanders
13. Birthplace Unk. (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Augusta (Unk.)
15. Birthplace Unk. (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Wm. A. Sanders

(b) Address Mt. Grove, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/3/46 (Month) (Day) (Year)

(c) Place: burial or cremation Jonesboro, Arkansas

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 2/5/46 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2 year 1946 hour 5:00 minute P. M.

21. I hereby certify that I attended the deceased from 2/2/46, 19, to 2/2, 1946 that I last saw her alive on 2/2/46, 19 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to	
Due to	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Guy D Calloway (M. D. or other) MD

Address Springfield Mo. Date signed 2/5/46

(Licensed Embalmer's Statement on Reverse Side)

JUL 24 1948

FEB 25 1948

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 Walter E. Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield Mo.

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.