

FILED SEP 23 1946

Registration District No. 199

Primary Registration District No. 4311

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Callao  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Entire life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61  
(c) City or town Callao 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. 1 (If rural, give location) 0  
(e) Citizen of foreign country? — (Yes or No)  
If yes, name country —

3. (a) PRINT FULL NAME

MINNIE L. SANDERS

(b) If veteran, name war ✓

(c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased 7-22-1870  
(Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 4 If less than one day hr. — min. —

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

10. Usual occupation Domestic

11. Industry or business

12. Name James S. Sherron  
13. Birthplace Macon Mo (City, town, or county) Mo (State or foreign country)  
14. Maiden name Macon white  
15. Birthplace Macon Mo (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs. Saunders  
(b) Address Callao Mo  
17. (a) Burial (b) Date thereof 8-28-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Local - Stone Cen  
18. (a) Signature of funeral director H. F. Salway  
(b) Address 207 W. 7th  
19. (a) Sept. 17, 1946 (b) H. F. Allen  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 26 year 1946 hour 5 minute — M.  
21. I hereby certify that I attended the deceased from 8-26-46 to 8-26-46 1946  
that I last saw her alive on 8-26-46 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cholecystitis  
Due to Acute Cholecystitis  
Due to —

Other conditions arteriosclerosis  
Chronic nephritis  
Of operations —  
Of autopsy L 127A

Duration 8-25-46  
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) Means of injury —  
23. Signature H. F. Allen (M. D. or —)  
Address Callao Mo Date signed 9/1/46

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 10  
District File Number 9-46-1771  
Date Filed SEP 23 1946

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

*H. G. Edwards*

Licensed Embalmer No.

1961

P. O. Address

*Brewer, 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.