

No. 2  
-1/47  
5-17-39

Registration District No. **318** Primary Registration District No. **1003**

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: **Homer G. Phillips Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 mos**  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3042 Cass Avenue**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Isaac Sanders**  
3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex **Male** 2 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **2** Wid. **1**  
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **July 15 1878**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**68 8 20** ..hr. ....min.

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

10. Usual occupation **Laborer**

11. Industry or business.....

12. Name **H. Sanders**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mildred Carey; daughter**  
(b) Address **3225 Bell Ave.**

17. (a) **Removal** (b) Date thereof **7-9-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **E. Higginsville**

18. (a) Signature of funeral director **E. Higginsville**

(b) Address **1318 E. Broadway**

19. (a) **APR 9 1947** (b) **J. H. Dredet**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **5**  
year **1947** hour **6** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **2-10**, 19 **47**, to **4-5**, 19 **47**, that I last saw him alive on **April 5**, 19 **47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach** Duration **undet.**

Due to.....

Due to.....

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy **None**

PHYSICIAN  
Underline the cause of 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 **Edw B. Williams** (M. D. or other).....

Address **2601 N. Whittier** Date signed **4/7/47**

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

MOTHER FATHER

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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

*P. W. Green*

Licensed Embalmer No.

*1173*

P. O. Address

*13186 Parkway*

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.