No. 2
24-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 14 1947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16095

Registration District No. 232 | Primary Registration District No. 3074 | Registrar's No. 39

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

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Sikeston (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sikeston General Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 hrs (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Morehouse (If outside city or town limits, write "RURAL") 72
(d) Street No.: 3 (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country: 1

3. (a) PRINT FULL NAME: Robert Lee Sanderson
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Rosie Sanderson
6. (c) Age of husband or wife if alive: 65 years
7. Birth date of deceased: April (Month) - 6 (Day) - 1876 (Year)

8. AGE: Years	Months	Days	If less than one day
71	1	1	hr. min.

9. Birthplace: Grayson County Ky. (City, town, or county) (State or foreign country)
10. Usual occupation: Merchant
11. Industry or business: Self
MOTHER FATHER
12. Name: Sam Sanderson
13. Birthplace: Kentucky (City, town, or county) (State or foreign country)
14. Maiden name: Martha Harper
15. Birthplace: Kentucky (City, town, or county) (State or foreign country)
16. (a) Informant: Wife
(b) Address: Morehouse Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Paducah Ky.
18. (a) Signature of funeral director: Orville Taylor
(b) Address: Sikeston Missouri
19. (a) 5-9-47 (Date received local registrar) (b) Mrs P. F. Henry (Registrar's signature) 23

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th year 1947 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw him alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of the Skull
Due to: By Train Accident
Due to:
Other conditions (Include pregnancy within 3 months of death): Crushed Shoulder
Major findings:
Of operations:
Of autopsy:

Duration

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: 100
(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: 3
23. Signature: Orville Taylor (M.D. or other) Coroner Scott Co.
Address: Sikeston Mo. Date signed 5-8-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No
District File Number 5-42-
Date Filed 5-12-42

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 James M. Scott

Licensed Embalmer No. 4250

P. O. Address East Bruce, T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 39

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: Sikeston General Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution few hours (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Morehouse (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

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

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Rosie Sanderson

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

7. Birth date of deceased April (Month) 6 (Day) 18 (Year)

8. AGE: Years 71 Months 1 Days If less than one day hr. min.

9. Birthplace Gray Co. (City, town, or county) Ky (State or foreign country)

10. Usual occupation Retired Mechanic

11. Industry or business

FATHER
12. Name Sam Sanderson
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Harper
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Wife

(b) Address Morehouse Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-47 (Month) (Day) (Year)

(c) Place: burial or cremation Paducah Ky.

18. (a) Signature of funeral director Orville Taylor

(b) Address Sikeston Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May 7 year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Crushed Arm and Fractured Skull.

Due to Hit by Train

Due to

Other conditions (Include pregnancy within 3 months of death) 170 e-8

Major findings:
Of operations

Of autopsy Auto Invoice

Duration

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) Accident

(b) Date of occurrence May 7 1947

(c) Where did injury occur? Morehouse (City or town) New Madrid (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Crossing of Missouri Pacific Crossing (Specify type of place)

While at work? no (e) Means of injury

23. Signature Orville Taylor Coroner of Scott Co. (M.D. or other)

Address Sikeston Mo Date signed 5-16-47

SUPPLEMENTARY

16095