

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17004

Registration District No. 104

Primary Registration District No. 4176

Registrar's No. 17

1. PLACE OF DEATH:

(a) County DUNKLIN

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

(c) Name of hospital or institution: NONE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE
(Specify whether years, months or days)

In this community life time

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DUNKLIN 35

(c) City or town MAIDEN (If outside city or town limits, write "RURAL") 3

(d) Street No. 1 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country _____

3. (a) PRINT FULL NAME Robert Berton Sanders

3. (b) If veteran, name war NONE

3. (c) Social Security No. No

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Ruth Carson Sanders

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

7. Birth date of deceased October 26 1881
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th year 1947 hour 11:00 minute 9 A.M.

21. I hereby certify that I attended the deceased from June 1st 1947 to May 10th 1947 that I last saw him alive on May 10th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>6</u>	<u>14</u>	hr. min.

Due to Cerebral Haemorrhage 1 1/2 hrs

Due to Paralysis right side 1 1/2 hrs

Other conditions Lobar Pneumonia 5 days
(Include pregnancy within 3 months of death)

9. Birthplace MAIDEN MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation Accountant

11. Industry or business accounting

12. Name Robert Fulton Sanders

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

14. Maiden name Missouri Constance Bragg

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

16. (a) Informant Mrs. H. Burks Davis

(b) Address Maiden - Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge - Kennett, Mo.

18. (a) Signature of funeral director Paul Salomon

(b) Address Kennett, Mo.

19. (a) 5/15/47 (Date received local registrar)

(b) J. B. Schuman (Registrar's signature) 27

Major findings: 53A

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? U

While at work? _____ (Specify type of place) _____ (Means of injury)

23. Signature S. E. Mitchell (M. D. or other M.D.)

Address Maiden, Mo. Date signed 5/12/47

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 547-723

Date Filed 5-29-47

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.....

Alfred F. Lemonds, Registered Apprentice No. 415
working under my personal supervision.

Signed

Alfred F. Lemonds
Licensed Embalmer No. 2556

P. O. Address Ferris, 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.