

FILED JUL 8 1947

Registration District No. **218**

Primary Registration District No. **5788**

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

1. PLACE OF DEATH:

(a) County Miss

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Sam Sanders

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 2. Color or race col

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

6. (b) Name of husband or wife Rachel Sanders

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

alt: 166

9. Birthplace Starkeville, Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Gus Sanders

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

14. Maiden name Lucinda

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

16. (a) Informant Chuck Sanders

(b) Address Elm Street No. 1725

17. (a) Burial (b) Date thereof 6-10-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Luke

18. (a) Signature of funeral director St. Luke

(b) Address St. Luke

19. (a) 6-30-47 (b) Gertrude J. Harper  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miss

(c) City or town Rural  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10<sup>th</sup>  
year 1947 hour 1:00 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 10, 1947 to June 10, 1947  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Cancer stomach Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 46B 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. J. Martin (M. D. or other)

Address East Prairie Date signed 6-10-47

RECEIVED

District Health Office, No. 2

District File Number ~~5-2-47~~

also Filed 7-2-47

JUL 8 1947

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 John H. German

Licensed Embalmer No. 4355

P. O. Address Hyattsville, Md. Box 424

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.