

FILED JUN 25 1947

Registration District No. 328

Primary Registration District No. 6100 (6101)

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Scotland
 (b) City or town Wichita, Kan
 (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 17
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME CHARLES SANDERS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race black
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 20 1905
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 4 4 hr. min.

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

10. Usual occupation Laborer

11. Industry or business mining train

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant information card

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Scott & Baskitt

(b) Address W. 44th St

19. (a) 6-19-47 (b) Mrs. E. F. Carrick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Kennett city 48
 (c) City or town _____ 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2115 Campbell 8
 (If rural, give location)
 (e) Citizen of foreign country? no 1
 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
Found Dead on Santa Fe RR track 19____ 19____
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
no suggestion for
no evidence

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

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 _____

(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 _____ 3

23. Signature OTR Bala (M. D. or other) Corona

Address Memphis MO Date signed 6/15/47

RECEIVED
District Health Officer No. 10
District File Number 6-47-262
Date Filed JUN 23 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..... *Paul Smith*

Licensed Embalmer No. *4856*

P. O. Address..... *Memphis*

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

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

Registration District No. *326*

Primary Registration District No. *6/01*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Scotland*
(b) City or town
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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 *Charles Sander*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *D*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Feb 10 1914*
(Month) (Day) (Year)

8. AGE: Years *42* Months *4* Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof *10/10/14*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* 19*14*
year *1914* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

23876