

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3214**
190

FILED JAN 19 1949

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 4 yrs. 8 mos		d. STREET ADDRESS (If rural, give location) 5351 Delmar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Home of Missouri			

3. NAME OF DECEASED (Type or Print)	a. (First) Mrs Sara	b. (Middle) Addie	c. (Last) Sanders	4. DATE OF DEATH (Month) (Day) (Year) 1 7 49
-------------------------------------	----------------------------	--------------------------	--------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 10-15-1865	9. AGE (In years last birthday) 83	10 UNDER 1 YEAR Months 2 Days 23	10 UNDER 6 HRS. Hours Min.
----------------------	-------------------------------	---	------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
--	--	---	--

13a. FATHER'S NAME Isaac Ross	13b. MOTHER'S MAIDEN NAME Kate Reeves	14. NAME OF HUSBAND OR WIFE James Lewis Sanders
--------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Iva Hirsch, 5351 Delmar, St. Louis
--	-------------------------------------	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis from Chronic		1 week
	ANTECEDENT CAUSES Senility Myocarditis		6 Mo
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Apr. 19, 1944**, to **Jan. 7, 1949**, that I last saw the deceased alive on **Jan. 7, 1949**, and that death occurred at **4.15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Iva Hirsch (Degree or title)	23b. ADDRESS 508 N. Grand Ave.	23c. DATE SIGNED 1-7-49
--	---------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-9-49	24c. NAME OF CEMETERY OR CREMATORY Fulton, Mo.	24d. LOCATION (City, town, or county) (State)
---	-------------------------	---	---

DATE REC'D BY LOCAL REG. JAN 7 1949	REGISTRAR'S SIGNATURE J. B. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe - St. Louis, Mo.
--	--	--

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Frank D. [Signature]

Signed _____

Student Embalmer

Licensed Embalmer No. *2675*

P. O. Address *[Signature]*

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.