

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 20448
2438

BIRTH NO. <u>29322-50</u>		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2438</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City MISSION 8150</u>		d. STREET ADDRESS (If rural, give location) <u>4830 MISSION ROAD</u> <u>St. Joseph Hospital</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Michael Joe</u>			b. (Middle)		c. (Last) <u>S A N D E R S</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 30, 1950</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>		8. DATE OF BIRTH <u>May 28, 1950</u>		9. AGE (In years last birthday) <u>3</u> # UNDER 1 YEAR # UNDER 1 MONTH # UNDER 1 WEEK Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Paul Sanders</u>			13b. MOTHER'S MAIDEN NAME <u>Earlene Ellen Martin</u>			14. NAME OF HUSBAND OR WIFE <u>-----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Paul Sanders, 4830 Mission Road, Mission, Ks</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Med. CERTIFICATION</u> <u>Not abdominal neurolysis</u>						INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Neurolysis of spine</u> <u>(Cause not definitely found)</u>						7710	
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Russell W. Kerr</u> (Degree or title)				23b. ADDRESS		23c. DATE SIGNED <u>31 May 50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/31/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>			
DATE REC'D BY LOCAL REG. <u>5-31-50</u>		REGISTRAR'S SIGNATURE <u>Heraldine Holmes</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Eylar, Kansas City, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
 Kansas City
 St. Joseph Hospital
 1930
 2 A M D E S
 MAY 28, 1930
 Kansas City, Missouri
 St. Joseph Hospital
 Kansas City, Missouri
 St. Joseph Hospital
 Kansas City, Missouri
 St. Joseph Hospital
 Kansas City, Missouri

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Doc W. Kirkendall

Signed.....
Student Embalmer

Licensed Embalmer No. 4632

P. O. Address K. C. 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.

St. Joseph Hospital, Kansas City, Missouri