

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10534**
Registrar's No. **2010**

FILED MAR 24 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5539 Southwest Ave.		d. STREET ADDRESS (If rural, give location) 5539 Southwest Ave.	

3. NAME OF DECEASED (Type or Print) ELIZABETH SANDERS		4. DATE OF DEATH (Month) (Day) (Year) Feb. 29 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Feb. 2, 1867
9. AGE (In years last birthday) 85		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME William Owens	13b. MOTHER'S MAIDEN NAME Elizabeth Eilenger	14. NAME OF HUSBAND OR WIFE Late William Sanders
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Frank Owens ADDRESS 20 Lincord Dr.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Hypertension		
	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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H222

22. I hereby certify that I attended the deceased from **10/27**, **1847**, to **2-29**, **1952**, that I last saw the deceased alive on **2-27**, **1952**, and that death occurred at **8:00P** m., from the causes and on the date stated above.

23a. SIGNATURE Andrew J. Klein, M.D. (Degree or title)	23b. ADDRESS 4632 So Grand	23c. DATE SIGNED 3-1-52
---	-----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 3, 1952	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Com.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	-------------------------------	---	---

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 3 1952	25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MO ADDRESS Kriegshauser 4228 S. Kingshighway Bl
---	---

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

13 10/10/10 10/10/10 10/10/10 10/10/10

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.

Student _____

Student Embalmer

10 10/10/10 10/10/10

Signed Richard W. Stovesand

10/10/10

Licensed Embalmer No. 4007

10/10/10

P. O. Address _____

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.