

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10440

State File No.

FILED MAR 31 1953

BIRTH NO. _____ REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 4267 Registrar's No.

540
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Odessa Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Odessa</u>	
c. LENGTH OF STAY (In this place) <u>20 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>H.</u> c. (Last) <u>Sander</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 25, 1953</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>June 27, 1879</u>			9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>0</u>		

13a. FATHER'S NAME <u>John Sander</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Lohman</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Sander</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>Mrs. Minnie Sander Odessa, Mo.</u>	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Cerebral Hemorrhage</u> <u>Left Hemiplegia</u> <u>Arteriosclerosis</u> DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>M</u>		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)		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 Several years, 19 , to March 25, 1953, that I last saw the deceased alive on March 25, 1953, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W.C. Martin M.D.</u>		23b. ADDRESS <u>Odessa Mo</u>		23c. DATE SIGNED <u>3-26-53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 28, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mayview Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Mayview, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>3/26/1953</u>		REGISTRAR'S SIGNATURE <u>Emma Davidson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Husman Sparks</u>		ADDRESS <u>Odessa, Mo.</u>	
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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

Signed William T. Sparks

Licensed Embalmer No. #4431

P. O. Address Odessa, 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.