

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 17 1953

BIRTH NO. _____ REG. DIST. NO. **374** PRIMARY REG. DIST. NO. **4554** Registrar's No. **9**

1930
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1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Monegaw Springs	c. LENGTH OF STAY (In this place) 4 years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Collins	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) Phyllis b. (Middle) Noel c. (Last) Sanders			4. DATE OF DEATH (Month) (Day) (Year) Feb; 8, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 10/24, 1927		9. AGE (In years last birthday) 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Clermont Wyoming /	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Walter W. Sanders	13b. MOTHER'S MAIDEN NAME Ada Britt		14. NAME OF HUSBAND OR WIFE		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ada Sanders, Monefaw Springs Mo. ADDRESS			
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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* (a) Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) Angina DUE TO (b) Angina the underlying cause is Angina 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 2 weeks
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 480X			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from **1-28, 1953** to **2-8, 1953**, that I last saw the deceased alive on **2-7, 1953**, and that death occurred at **3:30 A.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. Frank Judd M.D.	23b. ADDRESS Oscoble Mo.		23c. DATE SIGNED 2-9-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/11/53	24c. NAME OF CEMETERY OR CREMATORY Benton Green	24d. LOCATION (City, town, or county) (State) Roscoe Mo	
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DATE REC'D BY LOCAL REG. March 9-53	REGISTRAR'S SIGNATURE Chas Abney 2850	25. FUNERAL DIRECTOR'S SIGNATURE J. P. ... ADDRESS Oscoble Mo		
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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.

Student
Student Embalmer

Signed J. B. [Signature]

Licensed Embalmer No. 3038

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.