

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED SEP 15 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 3041 Registrar's No. 101

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Macon</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Macon</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>Main St. 064</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Fredrick</u> c. (Last) <u>Sandner</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 7, 1953</u>
--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 24, 1871</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 1000 Hrs. Hours <u>0</u> Mins. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Macon County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Fredrick Sandner</u>	13b. MOTHER'S MAIDEN NAME <u>Dora A. Hogan</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Sandner</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> <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Walter Sandner</u>	ADDRESS <u>St. Louis, 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		INTERVAL BETWEEN ONSET AND DEATH <u>See yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Prostate with Metastasis.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS: <u>Coronary thrombosis with myocardial damage</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>177X</u>	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) (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 Mar 15, 1951, to Aug 7, 1953, that I last saw the deceased alive on Aug 7, 1953, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Howard Miller M.D.</u>	23b. ADDRESS <u>Macon</u>	23c. DATE SIGNED <u>8/10/53</u>
---	------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Aug 10 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary</u>	24d. LOCATION (City, town, or county) (State) <u>Macon, Missouri</u>
--	---------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>8/31/53</u>	REGISTRAR'S SIGNATURE <u>Auth Mcneely</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Foster Dean</u>	ADDRESS <u>Macon Mo</u>
--	--	---	----------------------------

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

JUN 14 1954

SEP 11 1953

RECEIVED  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 9.53.177  
Date Filed 9.11.53

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

*R. Leslie Bram*

Licensed Embalmer No. 4472

P. O. Address *Macon, 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.