

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

675

State File No.

FILED FEB 15 1954

BIRTH NO. _____ REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jefferson City</u>		c. CITY OR TOWN <u>Jefferson City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>20 yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>307 Locust</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>307 Locust</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edward F</u> b. (Middle) _____ c. (Last) <u>Sanders</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 9-1954</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 27 1883</u>	9. AGE (In years last birthday) <u>70</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Fayetteville, Ark.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Pastus Sanders</u>	13b. MOTHER'S MAIDEN NAME <u>Mary P. Bayles</u>	14. NAME OF HUSBAND OR WIFE <u>Rose Sanders</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Rose Sanders</u>	ADDRESS <u>J.C. Mo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>2-3 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> 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 <u>331X</u>	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 1/29, 1951, to 2/9, 1954, that I last saw the deceased alive on 2/8, 1954, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Marshall Welch M.D.</u>	23b. ADDRESS <u>Jefferson City</u>	23c. DATE SIGNED <u>2/10/54</u>
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24a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Feb 12 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>River View</u>	24d. LOCATION (City, town, or county) (State) <u>Cole County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Feb 10-54</u>	REGISTRAR'S SIGNATURE <u>R.P. Harris MD-MR</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter - Linn - J.C. Mo.</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten scribble

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.....
Signature of Student Embalmer

Signed.....
[Handwritten Signature]

Licensed Embalmer No. *364*

P. O. Address *[Handwritten]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (To comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.