

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5215**

FILED MAR 8 1954

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2201 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Oklahoma b. COUNTY Delaware	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maysville, Arkansas	
d. FULL NAME OF HOSPITAL OR INSTITUTION Freeman Hospital		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print)	a. (First) Alex	b. (Middle) N.	c. (Last) Sanders	4. DATE OF DEATH (Month) (Day) (Year) 2 12 54
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 25, 1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF 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) Retired Minister	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Albany, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jesse Sanders	13b. MOTHER'S MAIDEN NAME Mary Duncan	14. NAME OF HUSBAND OR WIFE Bertha Ellen Sanders
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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 Daughter Mrs. Laura Vinyard	ADDRESS Maysville, Ark.
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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; asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH About 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic hypertensive arteriosclerotic heart disease. 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 None	19b. MAJOR FINDINGS OF OPERATION No operation.	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) (m.)	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 2-9-54, 1954, to 2-12-54, 1954, that I last saw the deceased alive on 2-12-54, 1954, and that death occurred at 9:45P m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title)	23b. ADDRESS 410 Jackson, Joplin, Mo.	23c. DATE SIGNED 3-3-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-15-1954	24c. NAME OF CEMETERY OR CREMATORY Maysville Cemetery	24d. LOCATION (City, town, or county) (State) Maysville, Arkansas
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DATE REC'D BY LOCAL REG. MAR 8 1954	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Siloam Springs, Ark.
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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 *E. P. Pratt*

Licensed Embalmer No. *3211*

P. O. Address *Siloam Springs, Ark.*

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.