

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35925**
Registrar's No. **9334**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) Ophelia		a. (First)		b. (Middle)	
c. (Last) Sanders		4. DATE OF DEATH		(Month) (Day) (Year) 10 11 54	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Unknown		9. AGE (In years) 67 yrs.		10. IF UNDER 1 YEAR (Specify) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) St. Charles, Mo.,	
12. COUNTRY OF WHAT COUNTRY? USA.		13a. FATHER'S NAME George Robinson		13b. MOTHER'S MAIDEN NAME Ophelia Anderson	
14. NAME OF HUSBAND OR WIFE Will Sanders		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 Orvill A. Sanders		ADDRESS 3622 Cozens Ave.,			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease with Decompensation		INTERVAL BETWEEN ONSET AND DEATH Undt.			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Cerebral Thrombosis with Right Arm Paresis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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? 443X	
22. I hereby certify that I attended the deceased from 10-7 , 19 54 , to 10-11 , 19 54 , that I last saw the deceased alive on 10-11 , 19 54 , and that death occurred at 6:40 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE Edw. B. Williams		(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 10-13-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/15/54	
24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		24d. LOCATION (City, town, or county) (State) St. Charles, Mo.,			
DATE REC'D BY LOCAL REG. OCT 14 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Lee J. Sneed	
				ADDRESS 3615 Easton Ave.,	

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.....
Signature of Student Embalmer

Signed..... *Leroy U. Fannin*.....
Licensed Embalmer No..... *45*.....
P. O. Address..... *3880 2nd*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.