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FILED JUN 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18579

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5388

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) 24 DAYS
c. CITY OR TOWN ST. LOUIS d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE HOSPITAL
e. STREET ADDRESS (If rural, give location) 6355 MINNIE AVENUE

3. NAME OF DECEASED
a. (First) William b. (Middle) FREDERICK c. (Last) SANDERS 4. DATE OF DEATH (Month) (Day) (Year) JUNE 3, 1956

5. SEX M 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH SEPT. 14, 1867 9. AGE (In years last birthday) Months Days If under 1 year If under 24 hrs. 86 8 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER 10b. KIND OF BUSINESS OR INDUSTRY BARBERING 11. BIRTHPLACE (City and State or Foreign Country) MILLSTADT, ILLINOIS 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME FREDERICK SANDERS 13b. MOTHER'S MAIDEN NAME MARGABET DREW 14. NAME OF HUSBAND OR WIFE EDITH 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 Edith Sanders ADDRESS 6355 MINNIE ST. LOUIS, Mo.

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.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Similar to hypertensive 0.16
ANTECEDENT CAUSES Paroxysmal hypertension
DUE TO (b) fractured 12 amp. fracture neck of R. vertebrae 6/6/56
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. as stated above

19a. DATE OF OPERATION None 19b. MAJOR FINDINGS OF OPERATION None 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 3-70-36 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Shamrock Nursing Home St. Louis, Mo. 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ST. LOUIS (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-15-56 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? Fall from chair at the corner

22. I hereby certify that I attended the deceased from 3-16-1936 to 6-3-1956, that I last saw the deceased alive on 6-3-1956, and that death occurred at 6:45 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. H. H. ... 23b. ADDRESS 2729 N. GRAND (ST. LOUIS) 23c. DATE SIGNED 6/4/56

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 24b. DATE 6/4/56 24c. NAME OF CEMETERY OR CREMATORY MOUNT HOLY 24d. LOCATION (City, town, or county) (State) EAST ST. LOUIS, ILLINOIS

DATE REC'D BY LOCAL REG. JUN 5 1956 REGISTRAR'S SIGNATURE ... 25. FUNERAL DIRECTOR'S SIGNATURE ... ADDRESS 1101 N. 9TH EAST ST. LOUIS ILLINOIS

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

(Licensed Embalmer's Statement of Reverse Side)

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..

Not Embalmed

Student.....
Signature of Student Embalmer

Signed..... *Joseph J. Kessley*

Licensed Embalmer No.....75.....

P. O. Address..... *E. H. Lewis*

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.