

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29077

State File No.

FILED SEP 7 1956

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BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Clayton 4452		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				e. STREET ADDRESS (If rural, give location) 7718 Maryland Avenue			
3. NAME OF DECEASED (Type or Print)		a. (First) LILLIAN		b. (Middle) MATTHEWS		c. (Last) SANFORD	
4. DATE OF DEATH		July 14th, 1956		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH September 15th, 1867		9. AGE (in years last birthday) 88		10. IF UNDER 1 YEAR Months 9 Days 29	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME George Matthews		13b. MOTHER'S MAIDEN NAME Mary Cunnington	
14. NAME OF HUSBAND OR WIFE John McDonald Sanford		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. F. D. McDonald	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of transverse colon with metastases to liver lung & bone		DUE TO (b) _____				Indef.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		153 x	
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 Feb 14, 1956, to July 14, 1956, that I last saw the deceased alive on July 11, 1956, and that death occurred at 5:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Sam Deau Mal				23b. ADDRESS 35 No Central - 5-		23c. DATE SIGNED 7/14/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/16/56		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. JUL 16 1956		REGISTRAR'S SIGNATURE Carl Smith MS		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons 7233 Delmar Blv'd.			

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 *Clarence H. Murrell*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis*

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.