

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33265

State File No.

FILED OCT 17 1956

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 499

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u>		c. CITY OR TOWN <u>Puxico</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) <u>Route # 2</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Poplar Bluff Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WILLIAM</u>	b. (Middle) <u>A.</u>	c. (Last) <u>SANDERS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 17, 1956</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>May 29, 1913</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u>	IF UNDER 24 HRS. Hour <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>crop farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Portageville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James A. Sanders</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Tyson</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Halcy Sanders</u>
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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) <u>No.</u>	16. SOCIAL SECURITY NO. <u>489-18-3257</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Halcy Sanders</u>	ADDRESS <u>Puxico, Mo. R. # 2</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3-4 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Duodenal Ulcer, Bleeding</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Duodenal Ulcer, Chronic</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 <u>17 Sept 56</u>	19b. MAJOR FINDINGS OF OPERATION <u>Bleeding Duodenal Ulcer</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) 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 14 Sept, 1956, to 17 Sept, 1956, that I last saw the deceased alive on 17 Sept, 1956, and that death occurred at 3 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>George C. Olive M.D.</u>	(Degree or title) (Address) <u>Poplar Bluff, Mo.</u>	23c. DATE SIGNED <u>9 Oct 56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sep. 19, 56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bloomfield cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Bloomfield, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10/11/56</u>	REGISTRAR'S SIGNATURE <u>R.H. Muehleman</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>CHILES UND. CO.</u>	ADDRESS <u>BLOOMFIELD, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

489

RECEIVED

OCT 15 1956
BUTLER CO. HEALTH CENTER

FILE NO. _____

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, & by Lulu Cooper #3499 ~~Student Embalmer~~ ~~Not~~ working under my personal supervision..

Student ~~XXXXXXXXXX~~ ~~XXXXXXXXXX~~ ~~XXXX~~
Signature of Student Embalmer
XXXXX X

Signed Juan B. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, M

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.