

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9007

FILED MAR 20 1957
BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 State File No. _____ Registrar's No. 104

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Independence	c. LENGTH OF STAY (In this place) 1 day	c. CITY OR TOWN Blue Springs	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Independence San & Hospital		e. STREET ADDRESS (If rural, give location) Cemetery Rd 1/2 Mile West 7600	

3. NAME OF DECEASED (Type or Print) a. (First) Mollie b. (Middle) C c. (Last) Sanders	4. DATE OF DEATH (Month) (Day) (Year) Mar 10 1957
---	---

5. SEX Fm	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 26 1903	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Mins. _____
------------------	----------------------------	---	-------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) De Queen Ark	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	---

13a. FATHER'S NAME Graham H Cravens	13b. MOTHER'S MAIDEN NAME Eugenia Miller	14. NAME OF HUSBAND OR WIFE Lyle D Sanders
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lyle D Sanders	ADDRESS Blue Springs 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic Coma		INTERVAL BETWEEN ONSET AND DEATH 26 hr.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus		
	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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
------------------------------	--	--

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) Blue Springs Mo
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	---	----------------------------------

22. I hereby certify that I attended the deceased from 3-9, 1957, to 3-10, 1957, that I last saw the deceased alive on 3/10, 1957, and that death occurred at 10:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Merrill R. Bay M.D.	23b. ADDRESS Blue Springs Mo	23c. DATE SIGNED 3/11/57
---	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 13-57	24c. NAME OF CEMETERY OR CREMATORY Blue Springs	24d. LOCATION (City, town, or county) (State) Blue Springs Mo
---	----------------------------	--	--

DATE REC'D BY LOCAL REG. 3-13-57	REGISTRAR'S SIGNATURE J. M. Kelly	25. FUNERAL DIRECTOR'S SIGNATURE Webb	ADDRESS Webb Funeral Home Blue Springs Mo
---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

3540

MAR 18 1957

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..... *R. B. Webb*

Licensed Embalmer No. *2357*

P. O. Address *Blue Spring*

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.