

1. Health,
& Welfare
5. Public
th Service

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

38094
STATE FILE NUMBER
10582
Registrar's No.

FILED NOV 15 1957

Registration District No. 318 Primary Registration District No. 1003

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF HOSPITAL OR INSTITUTION 4130 Russell ave.		d. STREET ADDRESS (If outside, give location) 4130 Russell ave	
3. NAME OF DECEASED (Type or print) First Middle Last HATTIE SANDERS.		4. DATE OF DEATH Month Day Year 11-1-57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Calloway, Ky.
13a. FATHER'S NAME Alex Williams		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Otis 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 Address John Sanders, 4218 Castleman
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Vascular Heart Disease Aug 1 1954</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Aug 1-1954</i> to <i>Oct 10-1957</i> and last saw her alive on <i>Oct 10-1957</i> Death occurred at <i>3:30 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>A. J. Moore M.D.</i> (Degree or title)		22b. ADDRESS <i>917-3018</i>	
22c. DATE SIGNED <i>Nov 2-1957</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		23b. DATE <i>11-2-57</i>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <i>Tullahoma, Tenn.</i>	
24. FUNERAL DIRECTOR <i>Rowland-Aker, 4104 Manchester</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>NOV 7 57</i>	
26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> <i>S.P.</i>			

140-5
02/11/10

8/1/10

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 *Harvey Koble*

Licensed Embalmer No. *4596*
P. O. Address *Flouissant*

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.