

Health,
& Welfare
Public
Service

S. 300
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38097

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9774

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>1</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4300 STRODTMAN</u>				Length of stay in lb <u>58 YRS. 9</u>		STREET ADDRESS (If outside, give location) <u>4300 STRODTMAN</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER W.M. SANDERS</u>				4. DATE OF DEATH		Month <u>10</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 19, 1899</u>	
9. AGE (In years last birthday) <u>58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT CUTTER</u>		100. KIND OF BUSINESS OR INDUSTRY <u>MEAT MKT.</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	
13. FATHER'S NAME <u>W.M. SANDERS</u>				14. MOTHER'S MAIDEN NAME <u>CLARA UNK.</u>			
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>492-05-1807</u>		17. INFORMANT <u>EVELYN SANDERS</u> Address <u>4300 STRODTMAN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>						Sudden	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetes Mellitus</u>							
DUE TO (c) <u>Mid-thigh amputation of right leg Oct. 3, 1957</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mid-thigh amputation of right leg Oct. 3, 1957</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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 _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <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 <u>Aug. 23, 1957</u> to <u>Oct. 17, 1957</u> and last saw <u>him</u> alive on <u>Oct. 17, 1957</u> Death occurred at <u>8:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James J. Hadley</u> (Degree or title)				22b. ADDRESS <u>634 North Grand, St. Louis 3, Mo.</u>		22c. DATE SIGNED <u>10/18/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-21-1957</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>FRIEDENS</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>	
24. FUNERAL DIRECTOR <u>Quedmeyer & Sons</u> ADDRESS <u>3434 N. 20TH</u>			25. DATE RECD. BY LOCAL REG. <u>OCT 18 57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		

(Licensed Embalmer's Statement on 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. . .

Student
Signature of Student Embalmer

Signed *Gustav W. Dieter*

Licensed Embalmer No. *43*

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.