

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41615**

FILED DEC 2 - 1957

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **277**

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|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY ST. CHARLES | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. CHARLES | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. CHARLES | | c. LENGTH OF STAY (in this place) 50 YRS | c. CITY OR TOWN ST. CHARLES | | 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 ST. JOSEPHS HOSPITAL | | | e. STREET ADDRESS (If rural, give location) 1722 No. FIFTH STR | | |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) LEE c. (Last) SANDERS SR | | | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 27 1957 | | |
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|-----------------|---------------------------|--|---------------------------------------|---|---|--|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M. | 8. DATE OF BIRTH FEB. 18. 1904 | 9. AGE (In years last birthday) 53 | IF UNDER 1 YEAR Months 9 Days 9 | IF UNDER 4 HRS. Hours Min. |
|-----------------|---------------------------|--|---------------------------------------|---|---|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | 11. BIRTHPLACE (City and State or Foreign Country) WAYNESVILLE MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
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| 13a. FATHER'S NAME JAMES SANDERS | | 13b. MOTHER'S MAIDEN NAME PEARLIE JONES | | 14. NAME OF HUSBAND OR WIFE ROSIE M. TIETZ SANDERS | |
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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) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME Rosie M. Sanders ADDRESS ST. CHARLES MO. | |
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Branchogenic carcinoma | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr., 4 mo | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 162X | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 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? | |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from **8-9-56**, 19____, to **11-27-57**, 19____, that I last saw the deceased - alive on **11-27-57**, 19____, and that death occurred at **2:15^{PM}** m., from the causes and on the date stated above.

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| 23a. SIGNATURE Paul H. Kother (Degree or title) M.D. | | 23b. ADDRESS 114 N. Main St., St. Charles, Mo. | | 23c. DATE SIGNED 11-29-57 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE Nov. 29. 1957 | 24c. NAME OF CEMETERY OR CREMATORY ST. JOHNS EV. REF. CEM. | 24d. LOCATION (City, town, or county) (State) ST. CHARLES. MO | | |
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| DATE REC'D BY LOCAL REG. Nov. 29-57 | | REGISTRAR'S SIGNATURE Marecella Wilson | | 25. FUNERAL DIRECTOR'S SIGNATURE B. L. Prinster. ADDRESS _____ | |
|--|--|---|--|---|--|

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

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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.....
E. J. Penelux

Licensed Embalmer No. *4283*

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.