

pt. Health,
, & Welfare
S. Public
alth Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 13 1957

318

1003

42558
STATE FILE NUMBER
11745

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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) St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 1436 Kentucky Ave		Length of stay in lb 37 years		STREET ADDRESS (If outside, give location) 1436 Kentucky Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN MILTON SANDERS				4. DATE OF DEATH Month Day Year December 6, 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1885		9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Truck Driver		11. BIRTHPLACE (City and state or country) Nashville, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Sophie Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none			16. SOCIAL SECURITY NO. 492-05-1147		17. INFORMANT Mrs. Sophie Sanders			Address 1436 Kentucky Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of lung hemorrhage of lung Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) hemorrhage of lung DUE TO (c) 163+							INTERVAL BETWEEN ONSET AND DEATH 6-Months		
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 WORK <input type="checkbox"/> 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 11-1-57 to 12-5-57 and last saw him alive on 12-5-57 . Death occurred at 8:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Elwin P. Scott (degree or title) Elwin P. Scott M.D.				22b. ADDRESS 3258 Lafayette 3258 Lafayette				22c. DATE SIGNED 12-7-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)			
Removal		Dec 9, 1957	Laurel Hill Gardens			St. Louis County, Missouri.			
24. FUNERAL DIRECTOR Shepard Funeral Home,				ADDRESS 1167 Hamilton Ave.		25. DATE RECD. BY LOCAL REG. DEC 7 '57		26. REGISTRAR'S SIGNATURE J. Earl Smith MD	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 Elton H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.