

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032482

STATE FILE NUMBER

FILED OCT 6 1958

Registration District No. 141 Primary Registration District No. 3095 Registrar's No. 63

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Hovell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hovell</u>					
b. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>			Length of stay in lb <u>8 yrs</u>		d. STREET ADDRESS <u>128 S. Hill</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Lee</u> Last <u>Sanders</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>58</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19-1939</u>		9. AGE (In years last birthday) <u>17</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Camden Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Leo Sanders</u>			13b. MOTHER'S MAIDEN NAME <u>Marie Carter</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Marie Sanders West Plains Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Spastic infantile Paralysis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 mos age</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Epilepsy (grand mal)</u>		DUE TO (c) <u>Chronic myocarditis 351X</u>			Interval between onset and death <u>since 1950</u>	
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>									
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 <u>9-17-58</u> to <u>9-17-58</u> and last saw her alive on <u>9-15-58</u> Death occurred at <u>6:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Virgil B. Barty 2nd</u> (Degree or title)				22b. ADDRESS <u>West Plains Mo</u>				22c. DATE SIGNED <u>9-27-58</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)		23b. DATE <u>9-20-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>First Chapel</u>		23d. LOCATION (City, town, or county) <u>Flameville Mo</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Robert West Plains Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-2-58</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>				

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *A. A. Roberts* .....

Licensed Embalmer No. *3437* .....  
P. O. Address *West Hill* .....

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.