

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046495
STATE FILE NUMBER
11638
Registrar's No.

FILED DEC 22 1958 Registration District No. 318 Primary Registration District No. 1003

300
1-57

1. PLACE OF DEATH a. COUNTY HOSPITALE- 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS-		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS- Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) 25 HOSPITAL OR INSTITUTION CITY HOSPITAL #1		Length of stay in lb 219	d. STREET ADDRESS (If outside, give location) 2642 PINE ST Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SANDERS- WESSON			4. DATE OF DEATH Month Day Year 11 - 30 58			
------------------------------------------------------------------------------------	--	--	---------------------------------------------------------	--	--	--

5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1895	9. AGE (In years (last birthday)) 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------	------------------------------------------------	-------------------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) STEPHEN, ARKANSAS	12. CITIZEN OF WHAT COUNTRY? U.S.A
-------------------------------------------------------------------------------------------------------------	-----------------------------------	------------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME UN-NONE	13b. MOTHER'S MAIDEN NAME UN-NONE	14. NAME OF HUSBAND OR WIFE LINNIE WESSON WIFE
--------------------------------------	---------------------------------------------	----------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give dates of service) YES ARMY WWII	16. SOCIAL SECURITY NO. 431.1291381	17. INFORMANT Address MRS-BUTTS- 3527-CLARK
-------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	-------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. (Contrib.:-) Penetrating stab wound of abdomen		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) E 982X		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) with knife in the hands of		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. TYPE OF INJURY Homicide	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II (a) or (b).) with knife in the hands of	20c. TIME OF INJURY Hour Month, Day, Year 200 p.m. 11 27 58 1958	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	20e. CITY, TOWN, OR LOCATION St Louis	COUNTY MO	STATE
----------------------------------------	----------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	-------------------------------------------------	---------------------	-------

20c. TIME OF INJURY Hour Month, Day, Year 200 p.m. 11 27 58 1958	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	20e. CITY, TOWN, OR LOCATION St Louis	COUNTY MO	STATE
-------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	-------------------------------------------------	---------------------	-------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 800 A m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree of title) James M Kelly Esq	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 12-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVE	23b. DATE 12-5-1958	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETRY	23d. LOCATION (City, town, or county) (State) J-BARRACKS MISSOURI
------------------------------------------------------------	-------------------------------	---------------------------------------------------------------	-----------------------------------------------------------------------------

24. FUNERAL DIRECTOR PEASTON FUNERAL 5615 EASTON	ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 3 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, Jr
------------------------------------------------------------	---------	--------------------------------------------------	-------------------------------------------------------

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 21 1969

OCT 9 1962

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 *Leroy C. Gunnister*
Licensed Embalmer No. *4523*
P. O. Address *4251 Mackay*

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.