

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007597

STATE FILE NUMBER

2 1739

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

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-57

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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) OR TOWN Saint Louis,		c. CITY OR TOWN Saint Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital # 1		d. STREET ADDRESS 2702 Gamble St. (If outside, give location)	

3. NAME OF DECEASED (Type or print) First Middle Last Jesse NIM Sanders			4. DATE OF DEATH Month Day Year 2 16 59			
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5. SEX Male 2	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1912	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Day	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Sanders	13b. MOTHER'S MAIDEN NAME Lulu Tolbert	14. NAME OF HUSBAND OR WIFE None
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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. ?	17. INFORMANT Willie Sanders	Address 3324 LaSalle St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of the Neck</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Card Injury E902.0</i>	
	DUE TO (c)	

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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DEGREE OF INJURY OCCURRED. (See nature of injury in PART I or PART II of form 18.) <i> suffered in fall from tree</i>
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20c. TIME OF INJURY Hour Month, Day, Year 2 14 59	20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <i>185 Grand</i>	20f. CITY, TOWN OR LOCATION <i>St Louis Mo</i>	COUNTY <i>800</i>	STATE
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21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>655 A</i>	22a. SIGNATURE (Do not sign for) <i>Regina Queen</i>	22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>2/18/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>2/20/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Clark Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Pine Bluff Arkansas</i>
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24. FUNERAL DIRECTOR <i>Ellis Funeral Home,</i>	ADDRESS <i>2820 Stoddard St.</i>	25. DATE RECD. BY LOCAL REG. <i>FEB 18 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 Geilton E. Culkin

Licensed Embalmer No. 4198
P. O. Address: Waverly, N.J.

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.