

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028264

FILED VS AUG 24 1959

Registration District No. 0412 Primary Registration District No. 1000 Registrar's No. 843 STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 36yrs	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 908 Alabama		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 907 Alabama (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Dorothy Middle Marie Last Sanderson			4. DATE OF DEATH Month Aug Day 11 Year 1959		
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5. SEX Female	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 Aug 6, 1923	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Joseph, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William H. Chaney	13b. MOTHER'S MAIDEN NAME Martha Douglas	14. NAME OF HUSBAND OR WIFE Charles Sanderson
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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. Unk	17. INFORMANT Charles Sanderson Address St. Joseph, Mo
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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) Generalized Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of the Colon		Unk.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <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 St. Joseph, Mo	COUNTY Buchanan	STATE MO
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21. I attended the deceased from **7/13/59** to **Aug. 11, 1959** and last saw her alive on **8/10/59**
Death occurred at **8:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S.E. Melaney M.D.	22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED Aug. 12, 1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/13/59	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
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24. FUNERAL DIRECTOR John Deup ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Aug 18, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF S.E. Melaney, M.D. 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

~~my~~

Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John E. Repp

Licensed Embalmer No. 7986

P. O. Address St. Joseph

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.