

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-030759

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2, 7440**

INDEXED

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 St. Louis		Length of stay in 1b	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) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5337 Cote Brilliante		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Addison Sanderson			4. DATE OF DEATH Month Day Year 8 7 59		
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 4-16-1898	9. AGE (last birthday) 61	IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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 None		11. BIRTHPLACE (City and state or country) Holly Spring, Miss.	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Phil Sanderson		13b. MOTHER'S MAIDEN NAME Sarah Fralleys	
14. NAME OF HUSBAND OR WIFE Bessie Sanders		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. 492-09-2158	
17. INFORMANT Address Bessie Sanderson 5337 Cote Brilliante		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) 331A		INTERVAL BETWEEN ONSET AND DEATH 1 Week	
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 type="checkbox"/> No <input type="checkbox"/> Unknown		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 a.m. p.m. Month, Day, Year		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 8-7-59		COUNTY STATE 8-7-59	
21. I attended the deceased from 7-31-59 to 8-2-59 and last saw him alive on 8-2-59		Death occurred at 6:20 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Sydney O. Jones, M.D.</i>		22b. ADDRESS 2601 N. Whittier St.		22c. DATE SIGNED 8-8-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/14/59		23c. NAME OF CEMETERY OR CREMATORY Father Dickson	
23d. LOCATION (City, town, or county) St. Louis County, Missouri		24. FUNERAL DIRECTOR E. B. Roonee			
24. FUNERAL DIRECTOR ADDRESS 1221 North Grand		25. DATE RECD. BY LOCAL REG. AUG 11 '59		26. REGISTRAR'S SIGNATURE <i>Garland Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*
Licensed Embalmer No. 3462

P. O. Address *[Handwritten Address]*

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.