

**MURI DIVISIC OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039708**

STATE FILE NUMBER

Registration District No. FILED 88 NOV 23 1959 Primary Registration District No. 2000 Registrar's No. 1238

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>	Length of stay in 1b <b>8 hrs</b>	c. CITY OR TOWN <b>MTN. GROVE</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SPRINGFIELD BAPT.</b>		d. STREET ADDRESS (If outside, give location) <b>330 W-First St.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BEAULAH</b> Middle <b>VIDA</b> Last <b>SANDERS</b>	4. DATE OF DEATH Month <b>NOV.</b> Day <b>16</b> Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG-30-1896</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>16</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL TEACHER</b>	11. BIRTHPLACE (City and state or country) <b>STOCTON, TAN.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>GEORGE WESTFALL</b>	13b. MOTHER'S MAIDEN NAME <b>STELLA SHOWERS</b>	14. NAME OF HUSBAND OR WIFE <b>CHARLES SANDERS</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b></b>	17. INFORMANT Address <b>Ivan SANDERS MTN GROVE MO.</b>
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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) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b></b>	
	DUE TO (c) <b></b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>	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
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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.) <b></b>
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20c. TIME OF INJURY Hour <b></b> Month, Day, Year <b></b> s.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b></b>	20f. CITY, TOWN, OR LOCATION <b></b> COUNTY <b></b> STATE <b></b>
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21. I attended the deceased from **11/16/59** to **11/16/59** and last saw her **11/16/59** alive on **11/16/59**  
Death occurred at **6:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b></b>	22b. ADDRESS <b>Springfield Mo</b>	22c. DATE SIGNED <b>11/19/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>NOV. 19-59</b>	23c. NAME OF CEMETERY OR CREMATOR <b>HILL REST</b>	23d. LOCATION (City, town, or county) (State) <b>MTN. GROVE MO.</b>
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24. FUNERAL DIRECTOR <b>BARBER F.H., MTN. GROVE MO</b> ADDRESS <b></b>	25. DATE RECD. BY LOCAL REG. <b>11-20-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*W. W. Barber*

Licensed Embalmer No. 384

P. O. Address W. W. Barber

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.