

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007220

FILED VS MAR 2 1960 200

Primary Registration District No. 3041

Registrar's No. 32

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Macon County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Shelby				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Macon, Missouri		Length of stay in 1b 19 days		c. CITY OR TOWN Shelbyville, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Samaritan Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5mi. West of Bethel, Mo.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sidney Jackson Sanders			4. DATE OF DEATH Month Day Year Feb. 20 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1866	9. AGE (last birthday) 93	IF UNDER 1 YEAR Months Days Hours Min. 1 23	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Marion Co. Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Jackson Sanders			13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X			16. SOCIAL SECURITY NO. X	17. INFORMANT Address Mrs Glen Rainey, Shelbyville, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia Following Surgery for Fractured femur 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							INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell in home and fractured hip				
20c. TIME OF INJURY Hour Month, Day, Year 4:00 a.m. 2 -2-1960	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.) Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE 5 miles west of Bethel, Shelby, Missouri			
21. I attended the deceased from 2 February 1960 to 20 February 60 and last saw him alive on 20 February 1960 Death occurred at 3:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) As Wright				22b. ADDRESS Leonard, Missouri		22c. DATE SIGNED 2/22/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 22/1960	23c. NAME OF CEMETERY OR CREMATORY Oakridge Cemetery		23d. LOCATION (City, town, or county) (State) 4mi. South of Lenter, Mo				
24. FUNERAL DIRECTOR ADDRESS C.W. Musgrove, Bethel, Missouri.				25. DATE RECD. BY LOCAL REG. 2/26/60	26. REGISTRAR'S SIGNATURE Paul M. Nealey			

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 B. W. Musgrove

Licensed Embalmer No. 2719

P. O. Address Bethel, Va.

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.