

MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 1960

60-022999

STATE FILE NUMBER

Registration District No. 382 Primary Registration District No. 5545 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chariton Township</u>		c. CITY OR TOWN <u>Glasgow</u>	
Length of stay in 1b <u>Life</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10 mi n.e. Glasgow</u>		d. STREET ADDRESS (If outside, give location) <u>10 mi n.e. Glasgow</u>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>H.</u> Last <u>Sanders</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 1884</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	
11. BIRTHPLACE (City and state or country) <u>Chariton Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Herman Sanders</u>		13b. MOTHER'S MAIDEN NAME <u>Henrietta Klinkie</u>	
14. NAME OF HUSBAND OR WIFE <u>Helen Guilford Sanders</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>490-42-7857</u>		17. INFORMANT <u>Mrs. Carl H. Sanders</u> Address <u>Glasgow Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INQUIRY INTO DEATH BY STATE DEPT. <u>1 hr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardio-vascular. renal disease</u>		DUE TO (c) <u>1 yr.</u>	
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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> / <u> </u> / <u> </u>		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 COUNTY STATE	
21. I attended the deceased from <u>June 19, 1960</u> to <u>June 19, 1960</u> and last saw her/him alive on <u>June 19</u>		Death occurred at <u>11 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>M P Beech M.D.</u>		22b. ADDRESS <u>Fayette Mo.</u>	
22c. DATE SIGNED <u>7/2/60</u>		22d. LOCATION (City, town, or county) (State) <u>Shannondale Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 21, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osborne</u>	
23d. LOCATION (City, town, or county) (State) <u>Shannondale Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>July 2, 1960</u>	
24. FUNERAL DIRECTOR <u>Tremont Funeral Service</u> ADDRESS <u>Glasgow Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Walker Studley</u>	

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 *C. W. Fuimonth*

Licensed Embalmer No. 3978

P. O. Address Glasgow

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.