

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024927

FILED VS JUL 1 1960

318

1003

6006

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 6 Yrs.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3611 N. 25th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3611 N. 25th St.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LINNIE Middle EDNA Last SANDERS				4. DATE OF DEATH Month 6 Day 10 Year 60			
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 4/24/00	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Montauk, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Mont Cook			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE T. W. 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. None	17. INFORMANT Address T. W. Sanders, 3611 N. 25th			
18. CAUSE OF DEATH (Enter only one cause by line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Malignant Hypertension							3 yrs.
DUE TO (c) Chronic Nephritis							3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 445x						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	
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.) None			
20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m. None	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 July 10 - 1953 to 10/10/60 and last saw her ^{her} _{him} alive on 6/6/60 Death occurred at 6/10/60 4-45 P. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE John B. Caneva MD (Degree or title)				22b. ADDRESS 2105 So. Broadway		22c. DATE SIGNED 6/13/60 (State)	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/14/60	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) DeSoto, Mo. (State)			
24. FUNERAL DIRECTOR ADDRESS J. Lee Mothershead, DeSoto, Mo.			25. DATE RECD. BY LOCAL REG. JUN 13 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ms

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 Andrew H. England

Licensed Embalmer No. 4745

P. O. Address De Soto, Ga

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.