

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 22 1960

-60-029057

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2172

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton	Length of stay in 1b 19 yrs.	c. CITY OR TOWN Clayton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6408 Alamo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6408 Alamo

3. NAME OF DECEASED (Type or print) First James Middle Clifford Last Sanders			4. DATE OF DEATH Month July Day 20 Year 1960		
5. SEX Male	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 3/5/1888	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Post Office	11. BIRTHPLACE (City and state or country) Gainesville, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Elisah Sanders		13b. MOTHER'S MAIDEN NAME Rebecca Patrick		14. NAME OF HUSBAND OR WIFE Nellie M. 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. Unknown	17. INFORMANT Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchopneumonia			3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Emphysema + bronchiectasis		6 years.
	DUE TO (c) Arteriosclerotic heart disease		3 years.
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Clayton	COUNTY St. Louis	STATE Mo.
21. I attended the deceased from Oct. 15, 1957 to July 20, 1960 and last saw ^{her} him alive on July 19, 1960 . Death occurred at 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Notar John Erenell M.D.		22b. ADDRESS 6256 Clayton Rd. St. Louis 17, Mo	22c. DATE SIGNED 7-20-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/20/60	23c. NAME OF CEMETERY OR CREMATORY Gainesville Cemetery	23d. LOCATION (City, town, or county) Gainesville, Mo.

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-20-60	26. REGISTRAR'S SIGNATURE John C. Murphy
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Murr

Licensed Embalmer No. 374

P. O. Address St Louis

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.