

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033307

FILED VS SEP 7 1960 317

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 590 Registrar's No. 2435

INDEXED

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Florissant		c. CITY OR TOWN Florissant	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 100 DuBourg Lane		d. STREET ADDRESS (If outside, give location) 100 DuBourg LANE	

3. NAME OF DECEASED (Type or print) WARD P SANDERS	4. DATE OF DEATH Aug 12 1960
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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 13 1879	9. AGE (last birthday) 80
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired shoe worker	10b. KIND OF BUSINESS OR INDUSTRY WANDA 146	11. BIRTHPLACE (City and state or country) U S A	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME GEO. BENNETT SANDERS	13b. MOTHER'S MAIDEN NAME ANNA ELIZABETH KENDALL	14. NAME OF HUSBAND OR WIFE Pauline Sanders (Dec'd)
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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) No	16. SOCIAL SECURITY NO. 490-20-8279	17. INFORMANT Kenneth Sanders 6452 Oakland
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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) Gunshot wound of head, just above left ear	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	
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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Self inflicted gunshot wound of head
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20c. TIME OF INJURY 6:15 subject found	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) base of residence	20f. CITY, TOWN, OR LOCATION Florissant	COUNTY St. Louis	STATE Missouri
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Raymond H. Hark Coroner	22b. ADDRESS Clayton, Mo.	22c. DATE SIGNED 8/25/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug 16 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cem	23d. LOCATION (City, town, or county) St Louis	(State) MO
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24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois	25. DATE RECD. BY LOCAL REG. 8-15-60	REGISTRAR'S SIGNATURE John C. Murphy M.D.
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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 *James C. White*

Licensed Embalmer No. 4347

P. O. Address 2906 S

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