

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013570

STATE FILE NUMBER

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 66

FILED MAY 1 1961

1. PLACE OF DEATH a. COUNTY <u>Waverly</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Waverly</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>345</u>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Merivoid Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1127 N. Fairfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>David J.</u> Middle <u>Sanders</u> Last <u></u>			4. DATE OF DEATH Month <u>Apr</u> Day <u>8</u> Year <u>61</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>4-25-02</u>	9. AGE (last birthday) <u>59</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>Retired Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City, and state or country) <u>Plains Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>The Sanders</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Sanders</u>		13c. NAME OF HUSBAND OR WIFE <u>Archie Sanders</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, if unknown) (If yes, give war or states of service) <u></u>	16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Archie Sanders</u>	Address <u>West Plains Mo</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>		<u>4 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Renal failure</u>	<u>10 days</u>
	DUE TO (c) <u>Hypertensive arteriosclerotic heart</u>	<u>5 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Paraplegia 25 years duration</u>		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 type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from 1957 to 4/8/61 and last saw him alive on 4/8/61
Death occurred at 1:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M. L. Fowler M.D.</u>	22b. ADDRESS <u>West Plains Mo.</u>	22c. DATE SIGNED <u>4-25-61</u>
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23a. BURIAL OR CREMATION, if cremation, (Specify) <u>AS</u>	23b. DATE <u>4/9-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cereael</u>	23d. LOCATION (City, town or county) (State) <u>Cereael Mo</u>
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24. GENERAL DIRECTOR <u>Robert W. West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-27-61</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

JUN 8 1967

MAY 22 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

A. S. Roberts

Licensed Embalmer No. 3432

P. O. Address Bees & Co.

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.