

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026411

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 154

AMENDED

FILED JUL 10 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Lincoln Co.</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Charles</u>		Length of stay in lb <u>4 days</u>		c. CITY OR TOWN <u>Elsberry</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>St Joseph Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>605 N. Fifth St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Juanita</u> Middle <u>Edna</u> Last <u>Sanders</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/20/76</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (City and state or country) <u>Troy Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Samuel M. Bailey</u>				13b. MOTHER'S MAIDEN NAME <u>Karen Powell</u>				14. NAME OF HUSBAND OR WIFE <u>H.R. 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>None</u>		17. INFORMANT Address <u>H.R. Sanders Elsberry 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>Cerebral Hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>										?			
DUE TO (c) <u>Senility</u>										?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Had Cholelithiasis - Cholecystectomy 6/27/61</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					
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 _____ a.m. _____ 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		COUNTY		STATE			
21. I attended the deceased from <u>6/6/61</u> to <u>6/20/61</u> and last saw her/him alive on <u>6/29/61</u> Death occurred at <u>9:54 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Ben L. Macreese M.D.</u>						22b. ADDRESS <u>222 S. 2nd St. Charles Mo.</u>			22c. DATE SIGNED <u>6/30/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>7/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elsberry Cemetery</u>			23d. LOCATION (City, town, or county) <u>Elsberry Mo</u>					
24. FUNERAL DIRECTOR <u>Pauline Miller Elsberry Mo</u>						25. DATE RECD. BY LOCAL REG. <u>July 1-61</u>		26. REGISTRAR'S SIGNATURE <u>Maureen Wilson</u>					

JUL 13 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 Arthur C. Lane

Licensed Embalmer No. 2155

P. O. Address St Charles 7

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.