

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031427

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 317
 FILED AUG 28 1961

Primary Registration District No. 544

Registrar's No. 2368

STATE FILE NUMBER

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Length of stay in 1b <u>3 Yrs.</u> | c. CITY OR TOWN <u>Kirkwood</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>Bethesda Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>9645 Big Bend Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle Last <u>Sanford</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>21</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-19-69</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 9. AGE (last birthday) <u>91</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>- Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>William R. Sanford</u> | | 13b. MOTHER'S MAIDEN NAME <u>Martha Weagley</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>-</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 <u>Robert M. Sanford, 877 Longacre</u> Address | |
| 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>Carcinoma of the rectum with</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>general metastasis</u> DUE TO (b) <u>arteriosclerotic vascular disease</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 mo</u> <u>ch</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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>June 1959</u> to <u>Aug 21 1961</u> and last saw her <u>alive</u> on <u>Aug 20 1961</u> Death occurred at <u>5:55</u> <u>6 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>W. B. Graves M.D.</u> | | 22b. ADDRESS <u>Webster Graves Mo</u> | |
| 22c. DATE SIGNED <u>8/22/61</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | |
| 23b. DATE <u>8-24-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Barkley Cemetery</u> | |
| 23d. LOCATION (City, town, or county) <u>New London, Mo.</u> | | 24. FUNERAL DIRECTOR <u>Drehmann-Harral, 1905 Union Blvd.</u> | |
| 25. DATE RECD. BY LOCAL REG. <u>8-22-61</u> | | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> | |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

Dr. Theo. R. Stebert
2000 S. Broadway
Pr-6-4700
Hrs.-10-12-AM

Dr. Seabaugh
Lockwood & Gore
W0 1-5002
Hrs. 3-5 PM

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 Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address A. Travis

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.