

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010147
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 149

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 2 1962

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kinder Length of stay in lb 75 years
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 miles No. Burfordsville Inside Limits No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cape Girardeau
c. CITY OR TOWN Burfordsville Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 2 miles North Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
LOUIS ROBERT SANDER March 17 1962

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 6/27/1878 9. AGE (last birthday) 83 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) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Building 11. BIRTHPLACE (City and state or country) Tilsit, Mo. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME William Sander 13b. MOTHER'S MAIDEN NAME Mollie Gordon 14. NAME OF HUSBAND OR WIFE Deceased

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. XXXXXXX 17. INFORMANT Dale Sander Address Burfordsville, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure INTERVAL BETWEEN ONSET AND DEATH immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease 2 years
DUE TO (c) generalized arteriosclerosis 10 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Aug 7, 1961 to Sept. 7, 1961 and last saw him alive on Sept 7, 1961
Death occurred at _____ A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J.E. Hecker, M.D. 22b. ADDRESS Jackson, Mo 22c. DATE SIGNED March 23, 1962

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 3/19/1962 23c. NAME OF CEMETERY OR CREMATORY Fairview Cem. 23d. LOCATION (City, town, or county) Kinder Twp. Mo. (State) 1962

24. FUNERAL DIRECTOR McCombs Funeral Home ADDRESS Jackson, Mo 25. DATE RECD. BY LOCAL REG. 3-29-62 26. REGISTRAR'S SIGNATURE Juan Karter

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

APR 19 1962

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 Bruce Jackson

Licensed Embalmer No. 5097

P. O. Address Jackson MO

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.