

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030672

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 628

Primary Registration District No. 2000

Registrar's No. 1231

FILED AUG 21 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>			Length of stay in 1b <u>5 hrs.</u>		c. CITY OR TOWN <u>Hermitage</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>Burge Hospital</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Hermitage, Mo.</u>	
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Wadie</u> Last <u>Sanders</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>6-5-81</u>	
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Hermitage, Mo.</u>	
13a. FATHER'S NAME <u>Jacob H. Sanders</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy J. Robinson</u>			14. NAME OF HUSBAND OR WIFE <u>Grace Sanders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Grace Sanders, Hermitage, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Refractory shock</u>							<u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Acute myocardial infarction</u>							<u>19 hours</u>
DUE TO (c) <u>Atherosclerosis</u>							<u>several years</u>
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	
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 <u>8:45</u> a.m. p. Month, Day, Year <u>August 11, 1962</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.)		20f. CITY, TOWN, OR LOCATION <u>Wheatland, Missouri</u>	
21. I attended the deceased from <u>11 August 62 only</u> and last saw ^{her} him alive on <u>11 Aug 1962</u> Death occurred at <u>8:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Samuel E. Holmes MD</u>				22b. ADDRESS <u>600 S. Glenstone Springfield</u>		22c. DATE SIGNED <u>13 Aug 62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>August 11, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		23d. LOCATION (City, town, or county) (State) <u>Wheatland, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hathaway Funeral Home, Wheatland, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-20-62</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>	

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 8-11-63

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 Jewell E. Windle

Licensed Embalmer No. 4737

P. O. Address Springfield, 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.