

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH **JAN 6 1935**

County **Audrain**  
Township **East River**  
City **Meigs Mo** (No. **Audrain Co Hospital**)

Registration District No. **26**  
Primary Registration District No. **3012**

File No. **41862**  
Registered No. **181**

2. FULL NAME **Donald A. Sanders**  
(a) Residence, No. **Centralia Mo** St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **7-25-1929**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **5 1 28**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **ORA**  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **ORA**  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Audrain Mo**

13. NAME **Ernest Sanders**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Audrain Co Mo**

15. MAIDEN NAME **Betty Mize**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Boon Co Mo**

17. INFORMANT (ADDRESS) **Ernest Sanders Centralia Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Centralia Mo** DATE **12/24 1934**

19. UNDERTAKER (ADDRESS) **Wm. H. Hays Centralia Mo**

20. FILED **12/23 1934** **Blanche Reely** Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec 23 1934**

22. I HEREBY CERTIFY, That I attended deceased from **Dec 23 1934** to **Dec 23 1934**. I last saw him alive on **12:30 PM Dec 23 1934**. Death is said to have occurred on the date stated above, at **2 P.** m.

The principal cause of death and related causes of importance were as follows:  
**meningitis, result of ear infection.** Date of onset \_\_\_\_\_

Other contributory causes of importance:  
**Pneumonia**

Name of operation **None** Date of \_\_\_\_\_  
What test confirmed diagnosis? **Streptococcus** Was there an autopsy? **No**

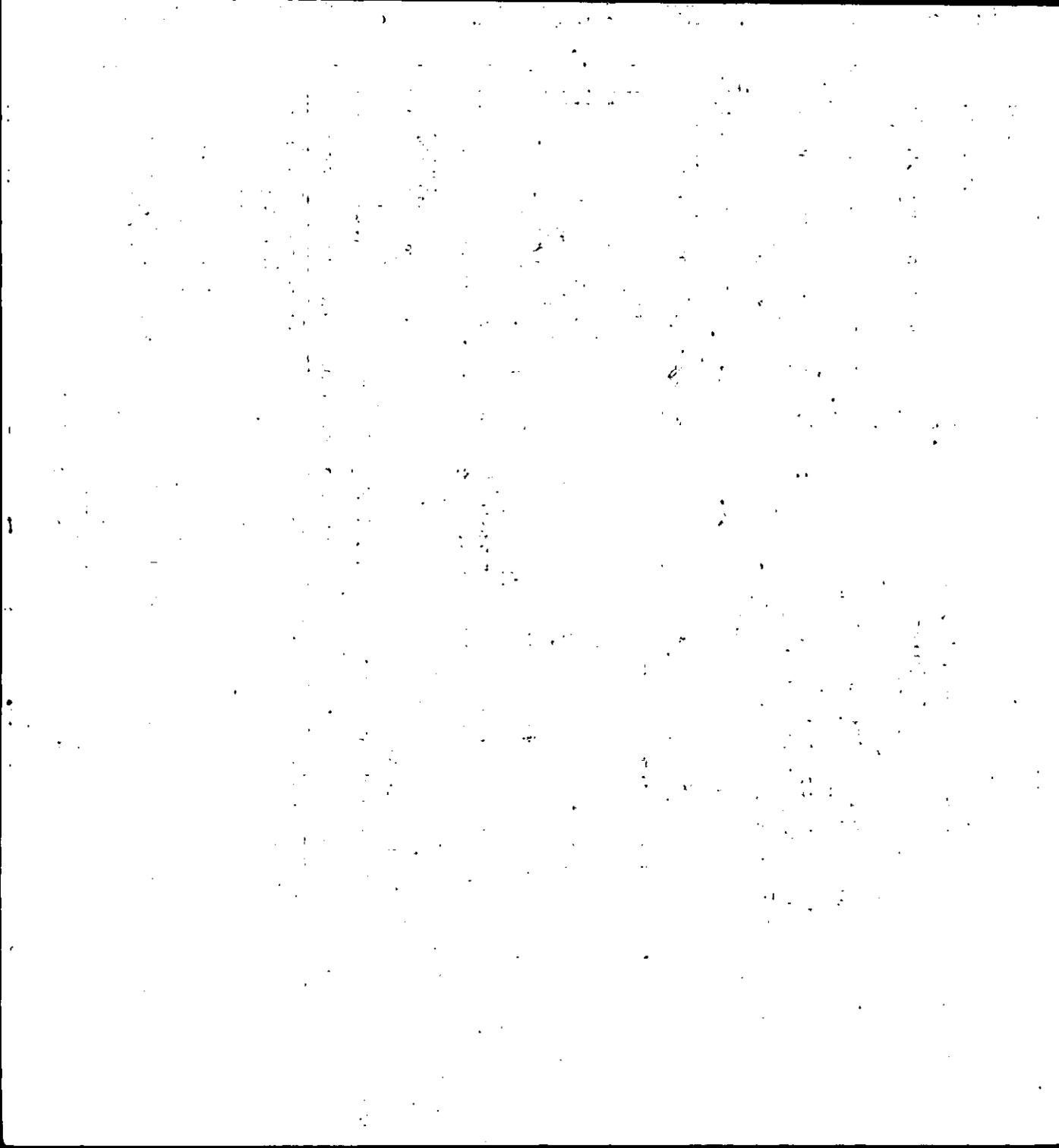
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify \_\_\_\_\_  
(Signed) **Fred Griffin**, M. D.  
(Address) **117 Wood Street Centralia Mo**

Every year of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Audrain  
Township \_\_\_\_\_  
City Mexico

Registration District No. \_\_\_\_\_  
Primary Registration District No. 3002

File No. \_\_\_\_\_  
Registered No. 187  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

5 1 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 12-23- 1934 Blanche Keely Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 23, 1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

Last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

meningitis - from year of death - non-contagious type  
suppurative meningitis  
pneumonia  
Other contributory causes of importance:  
Oedema of lungs  
mechanical type

Date of onset \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_.

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Paul J. Puffer M. D.

(Address) 117 East Main St. Mexico Mo.

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

JAN 25 1935

S-41862