

N. B.—Every item 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.

AUG 18 1936

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

Do not use this space.

28805

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis, Mo.** *of 771 Bayard St. to 791*

File No.....
Registered No. **7571**
St. Ward)

2. FULL NAME

Fred Sanders
771 Bayard St.

(a) Residence, No. St., **12** 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

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) **F eb. 8th. 1965**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 5 6

OCCUPATION 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. **Laborer**
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) **St. Louis, Mo**

FATHER 13. NAME **San ders**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Don't know**

MOTHER 15. MAIDEN NAME **Don't know**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Don't know**

17. INFORMANT **Mrs. Ida Sutter** (ADDRESS) **1525a Benton St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Valhalla Crematory** DATE **7-20-36**

19. UNDERTAKER **Henry Lechner, U. C.** (ADDRESS) **1417 N. Main St.**

20. FILED **JUL 18 1936** **J. F. Brebeck** Registrar.

No Phy. in attendance MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-14-1936**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....
I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at **9:20 A.M.**
The principal cause of death and related causes of importance were as follows:

Heart Stroke

Other contributory causes of importance: **191**

Name of operation Date of
What test confirmed diagnosis? 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?
If so, specify
(Signed) **Carol P. Jones** M. D.
(Address) **St. Louis**

