

REC'D APR 15 1939

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

11090
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 400
 (b) Township Pease Primary Registration District No. 5553B Registered No. 73
 (c) City _____ (d) Street No. Jackson County Home for the Aged St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank Sanders
 (a) Residence, No. J.C. Home St. _____ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 20 - 1862
 7. AGE YEARS 76 MONTHS 11 DAYS 22 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 1
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
 FATHER 13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 MOTHER 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 17. INFORMANT Ernest Jackson
 (ADDRESS) J.C. Home
 18. BURIAL, CREMATION, OR REMOVAL Keokuk Iowa DATE May 17 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rettler
Keokuk, Iowa
 20. FILED 3/15/39 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 12 1939
 22. I HEREBY CERTIFY, That I attended deceased from 2-1 1939, to 3-12 1939
 I last saw him alive on 3/10 1939 Death is said to have occurred on the date stated above, at 10:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Chronic myocarditis Date of onset _____
 Other contributory causes of importance: None
 Name of operation _____ Date of _____
 What test confirmed diagnosis Clinical 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) J. H. Green, M. D.
 (Address) Independence
Mo

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.