

1939 OCT 30 REC

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

33425
Do not use this space.

1. PLACE OF DEATH

(a) County..... St. Francois Registration District No. 773
(b) Township..... St. Francois Primary Registration District No. 6018A
(c) City..... Near Farmington (d) Street No. State Hospital No. 4 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Edward Sanders

(a) Residence, No. Lesterville, Mo. 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 (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1885
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 Un. Un.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Data 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) Unknown

FATHER 13. NAME John T. Sanders

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison County Missouri

MOTHER 15. MAIDEN NAME Mary G. Graham

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison County Missouri

17. INFORMANT (ADDRESS) Records of State Hospt. #4 Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Progras Cem Madison Mo DATE 9-28-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John A. Neidert Farmington, Mo.

20. FILED Sept 30 1939 93 J. Robinson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-26-39 19
22. I HEREBY CERTIFY, That I attended deceased from 6-5, 1939, to 9-26, 1939
I last saw h. im. alive on 9-26, 1939. Death is said to have occurred on the date stated above, at 11:30 pm.
The principal cause of death and related causes of importance were as follows:

Mental deficiency with psychosis (terminal exhaustion & generalized bronchopneumonia) & other contributory causes of importance: General Arterio sclerosis
Date of onset life

Name of operation none Date of no
What test confirmed diagnosis? Lab. & Clin 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? none (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 Chronic Granuloma

24. Was disease or injury related to occupation of deceased?
If so, specify
(Signed) F. Tivis Graves, Jr., M. D.
(Address) Farmington, 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.

WHILE COMPLETELY UNPAID THIS IS A PERMANENT RECORD

1 X1603

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

John Anderson

Licensed Embalmer No. *✓✓38*

P. O. Address *Farmington*

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.