DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38295

Registration District No. 1791

Primary Registration District No.

Registrar's No. 10134

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital #1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. ~~3405a~~ 3405 Gravois Ave. (If rural, give location)

(e) If foreign born, what country? No, U.S. Raw in Attendance

3. (a) PRINT FULL NAME Charles Sanders 536

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Josephine

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased May (Month) 27 (Day) 1897 (Year)

8. AGE: Years 42 Months 5 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Oiler

11. Industry or business City Employee

FATHER 12. Name Daniel Sanders

13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER 14. Maiden name Clementine

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Josephine Sanders

(b) Address 3405a Gravois Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/28/39 (Month) (Day) (Year)

(c) Place: burial or cremation Stanton, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) NOV 28 1939 (Date received by registrar) (b) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26 year 1939 hour 6 minute 25 P.M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h... alive on ....., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death FRACTURE OF SKULL; LACERATION OF BRAIN; SUFFERED WHEN DECEASED WAS INJURED WHILE WORKING ON WATER PUMP AT CHAIN OF ROCKS STATION BY GETTING HEAD CAUGHT BETWEEN WRIST PLATE ROD AND STEEL GIRDER ABOUT 5:25 P.M. Nov. 26 1939 — Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT

(b) Date of occurrence Nov 26, 1939

(c) Where did injury occur? St Louis, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? IN INDUSTRIAL PLACE (Specify type of place)

While at work? Yes (e) Means of injury machinery

23. Signature (M. D. or other)

Address Date signed 11.28.39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 1 X19511

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.....1861.....

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.