

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 39145Registration District No. 508Primary Registration District No. 3-026Registrar's No. 150

1. PLACE OF DEATH:

(a) County Livingston
 (b) City or town Chillicothe
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
328 S. Brunswick Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 10 years _____ years, months or days) _____

3. (a) PRINT FULL NAME Douglas Saunders

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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 21, 1875
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
65 0 26 hr. min.9. Birthplace Carroll County Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Farming

11. Industry or business _____

12. Name Clark C. Saunders13. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)14. Maiden name Catherine Powell15. Birthplace Carroll County Missouri
(City, town, or county) (State or foreign country)16. (a) Informant T. M. Saunders(b) Address 328 Brunswick Chillicothe, Mo17. (a) Burial (b) Date thereof 11-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Blue Mound Cem.18. (a) Signature of funeral director F. B. Norman Co.(b) Address Chillicothe, Missouri19. (a) 11-19-40 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")(d) Street No. 328 S. Brunswick Street
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Nov day 17
year 1940 hour 12 minute 15 a. M.21. I hereby certify that I attended the deceased from Nov. 16
1940, to Nov 17, 1940
that I last saw him alive on Nov 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Thrombosis 1 Day

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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

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

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

943
While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature A. Callen (M. D. or other) _____Address Chillicothe, MO Date signed 11/18-40

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.....

..... Elton F. Norman & E. R. Norman (2374), Registered Apprentice No.
working under my personal supervision.

Signed Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Mo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 39145
Registrar's No. 150

Registration District No. 508

Primary Registration District No. 3026

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

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Douglas Saunders

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 26 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-19-40 (b) H. M. Grace M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 17 year 1940 hour _____ minute _____ 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 _____
Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration _____
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) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature A. Collier (M. D. or other) _____
Address Chillicothe _____ signed _____

SUPPLEMENTARY

S-39145 1940