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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 8 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43390

State File No. _____

Registration District No. 1079

Primary Registration District No. 6274

Registrar's No. 16

1. PLACE OF DEATH: *03 Mark*

(a) County: _____

(b) City or town: *Rural, Pine Creek*
(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: _____ (Specify whether
In this community _____ years, months or days) *2 M, 11 days*

3. (a) PRINT FULL NAME: *BETTY Lou SANDERS*

3. (b) If veteran, name war: _____

3. (c) Social Security No.: *NO*

4. Sex: *F*

5. Color or race: *white*

6. (a) Single, widowed, married, divorced: _____

6. (b) Name of husband or wife: _____

6. (c) Age of husband or wife if alive: _____ years (Day) (Year)

7. Birth date of deceased: *Sept. 20 1940*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

2 11 hr. min.

9. Birthplace: *03 Ark Co MO*
(City, town, or county) (State or foreign country)

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER

12. Name: *Charles Sanders*

13. Birthplace: *03 Ark Co MO*
(City, town, or county) (State or foreign country)

14. Maiden name: *Marie Carter*

15. Birthplace: *03 Ark Co MO*
(City, town, or county) (State or foreign country)

16. (a) Informant: *Mrs. Nora Sanders*

(b) Address: *Zanoni MO*

17. (a) *Martha Sanders* (b) Date thereof: *12-2-40*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: *Burial*

18. (a) Signature of funeral director: *Joe Hutchinson*

(b) Address: *Zanoni MO*

19. (a) *12-2-40* (b) *J.T. White*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: *MO* (b) County: *03 Ark*

(c) City or town: *Rural Pine Creek*
(If outside city or town limits, write "RURAL")

(d) Street No.: *1 M N, by corner of MO*
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec*, day *1st*
year *1940* hour *11* minute *45 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: *NO physician saw wife, but gave history of ill care since of the physician at Med. Branchial pneumonia*

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? _____

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

23. Signature: *J.T. White* (M. D. or other) _____

Address: *Saintsville MO* Date signed: *12/2/40*

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

RECEIVED

District Health Officer No. 6,

District File Number: 41-3067.

Date Filed: JAN 3 1941

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.