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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Filed NOV 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34028

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3968

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
In car at rear of 407 Cambridge  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no  
In this community 2.5 yrs 3  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 048  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. M 3207 E 9th  
(If rural, give location)  
(e) Citizen of foreign country? Kansas City, Mo. (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME James Thomas Sanders

3. (b) If veteran, name war None 3. (c) Social Security No. 487-05-5124

4. Sex Male 0 5. Color or race Wh 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 7 18 1905  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
36 3 5  
hr. min.

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

10. Usual occupation Steel worker

11. Industry or business Sheffield Steel Corp.

MOTHER FATHER { 12. Name Charles W. Sultzbaugh  
13. Birthplace Auburn Nebr.  
(City, town, or county) (State or foreign country)  
14. Maiden name Pearl Sanders  
15. Birthplace Nebraska  
(City, town, or county) (State or foreign country)

16. (a) Informant Dean Sultzbaugh  
(b) Address 4325 Myrtle

17. (a) Cremation (b) Date thereof 10/25/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) 10/24/41 (b) M. D. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10-23-41  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 7A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw the deceased \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Pulmonary Hemorrhage & Edema

Due to Predix fork Investigator  
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) He was thrown  
(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?

(Specify type of place)  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Russell W. Jan (M. D. or other) 3  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

mc

**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 P. Shier*

Licensed Embalmer No. 3625

P. O. Address K<sup>o</sup> 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. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 3968

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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)

3. (a) PRINT FULL NAME James Thomas Sanders

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.....  
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 Months Days If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

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) 10/24/41 (b) M. H. Browe (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits write "RURAL")  
(d) Street No. 3968 E. 9th Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct. day 23  
year 1941 hour..... minute..... M.

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

Immediate cause of death Acute pulmonary hemorrhage & Edema

Due to Carbon monoxide poisoning

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) Unknown

(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 J. H. H. (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

34028