

No. 2
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DEPARTMENT OF COMMERCE
 RECEIVED NOV 19 1941

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 34780
34180

Registration District No. 19 Primary Registration District No. 113 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Atechison
 (b) City or town Rockport
 (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 Fifteen years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atechison 3
 (c) City or town Rock Port 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No)
 If (yes, name country) _____ 0

3. (a) PRINT FULL NAME Samuel Rider Sanders
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male race White 5. Color or race _____
 6. (a) Single, widowed, married, divorced Widower
 (b) Name of husband or wife unknown (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 6 1876
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>65</u> | <u>4</u> | <u>3</u> | hr. _____ min. |

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name James F. Sanders
 13. Birthplace Wardson (City, town, or county) (State or foreign country)
 14. Maiden name Thusan Catherine Langacker
 15. Birthplace Wardson (City, town, or county) (State or foreign country)

16. (a) Informant Wm Sanders
 (b) Address Rock Port Mo

17. (a) Burial (b) Date thereof Oct 11 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wardson

18. (a) Signature of funeral director J. B. Bertram
 (b) Address Rock Port Mo

19. (a) Oct 10 1941 (b) Mary S Chamberlain
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
 year 1941 hour 2 minutes _____ 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 Cerebral Hemorrhage
 Due to _____
 Due to _____

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) _____
 (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 Scott Fisher (City or town) (State) 3
 Address Westboro, Missouri Date signed 10/9/41

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

17011 PC

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 By Me
....., Registered Apprentice No.
working under my personal supervision.

Signed J. B. Beirson
Licensed Embalmer No. 4024
P. O. Address Rock Port 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.