DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5895

Registration District No. 10 | Primary Registration District No. 5037 | Registrar's No. 9

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Rual, Saltriver Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Audrain County Infirmry 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)
In this community 8 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain 4

(c) City or town Rual 0
(If outside city or town limits, write "RURAL")

(d) Street No. Audrain County Infirmry
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country C

3. (a) PRINT FULL NAME Charles Sanders

3. (b) If veteran, name war Unknown

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife

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

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

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace not known 9
(City, town, or county) (State or foreign country)

10. Usual occupation Resident - County infirmery

11. Industry or business

MOTHER FATHER

12. Name not known

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

14. Maiden name

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

16. (a) Informant Ed. Stuart

(b) Address Mexico, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 43 (Month) (Day) (Year)

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

18. (a) Signature of funeral director Earl E. Peck

(b) Address Mexico, Mo.

19. (a) 1-22-1943 (Date received local registrar) (b) Margaret H Mackie (Registrar's signature)

1094

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21st year 1943 hour 12 minute 30 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.

	Duration
Immediate cause of death	
Due to natural causes	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Ed Stuart, Acting Coroner (M. D. or other) C-Mo.

Address Mexico, Mo. Date signed 1-22-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-43-273
Date Filed FEB 15 1943

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 Earl E. Precht, Registered Apprentice No. ..... working under my personal supervision.

Signed Earl E. Precht

Licensed Embalmer No. 3189

P. O. Address Mexico, Mo.

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.

o. 2B
-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5695-

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 9

1. PLACE OF DEATH:

(a) County: Andrain

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Andrain Co. Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 yrs (Specify whether years, months or days)

In this community: yes

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Andrain

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

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Charles Sanders

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: M

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

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

7. Birth date of deceased: Do not know (Month) (Day) (Year)

8. AGE: Years 68 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 .....

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

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) 3/28/43 (Date received by registrar) (b) Margaret H Mache (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 21 year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 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 ..... Duration

Due to: High blood pressure

Due to .....

Other conditions (Include pregnancy within 3 months of death) 10 d

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)

(b) 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 Ed Shannon 3 Adv (M. D. or other)

Address Coroner, Andrain Co. Date signed 3-28-43

SUPPLEMENTARY