

DECEASED AUG 23 1943

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 months**
In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John Saunders**

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

4. Sex **MALE** 5. Color or race **COL.** 6. (a) Single, widowed, married, divorced **0**

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **4** years

7. Birth date of deceased: **10** (Month) **4** (Day) **1885** (Year)

8. AGE: **57** Years **10** Months **8** Days If less than one day hr. min.

9. Birthplace **St. Louis Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **LABOUR**

11. Industry or business

MOTHER FATHER { 12. Name **WILLIAM SAUNDERS**
13. Birthplace **KENTUCKY**
14. Maiden name **FANNIE SAUNDERS**
15. Birthplace **MISSOURI** (City, town, or county) (State or foreign country)

16. (a) Informant **BROTHER**
(b) Address **3713 EVANS**
17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **8-19-43** (Month) (Day) (Year)

(c) Place: burial or cremation **GREENWOOD CEMETERY**

18. (a) Signature of funeral director **William J. Allen**
(b) Address **4254 W. FINNEY**

19. (a) **AUG 11 1943** (Date received local registrar) (b) **J. J. Sullivan** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **2119**
(d) Street No. **1453 Webster** (If rural, give location)
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **13**, year **1943** hour **6** minute **30** A. M.

21. I hereby certify that I attended the deceased from **April 13**, 19 **43**, **August 13**, 19 **43** that I last saw him alive on **August 13**, 19 **43**; and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Penis with metastases**

Due to **U**
Due to **U**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **U**
Of autopsy **U**

Duration

Unk.

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 **W. K. Fleet** (M. D. or other) **8/16/43**
Address **2601 Webster** Date signed

COOK
MARR
10
8 11 82
1400221M 2100-49

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. 18322

P. O. Address

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.
Registrar's No. 7415

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer S. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo. (Specify whether
In this community _____ years, months or days) Life

3. (a) PRINT FULL NAME John Saunders

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

4. Sex m 5. Color or race B 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: Oct. 4 1888
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days _____ (Less than one day) _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Aug 22 1943 (b) J. F. Bruck
(Date received local registrar's certificate) (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. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 13 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-27041