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-43
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35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 14 1944

Registration District No. 329

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8503

Primary Registration District No. 4485

Registrar's No. 33

1. PLACE OF DEATH:

(a) County SCOTT

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

(c) Name of hospital or institution: Round House Hill 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Not in hospital (Specify whether)

In this community 81 yrs 0 mo - 0 days (years, months or days)

2. USUAL RESIDENCE OF DECEASED: 100

(a) State MISSOURI (b) County SCOTT 2

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

(d) Street No. Round House Hill 4 (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME ELIZABETH SANDER

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife FREDERICK W SANDER

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

7. Birth date of deceased MAR (Month) 31 (Day) 1862 (Year)

8. AGE: Years 81 | Months 10 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Ohio 1 (City, town, or county) (State or foreign country)

10. Usual occupation RETIRED HOUSE KEEPER

11. Industry or business

FATHER
12. Name JACOB WALTER
13. Birthplace GERMANY 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARGRET HOFFMAN
15. Birthplace GERMANY 4 (City, town, or county) (State or foreign country)

16. (a) Informant Herman Sander

(b) Address Fornfelt Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 28-1944 (Month) (Day) (Year)

(c) Place: burial or cremation ILLMO LUTHERAN CEMETARY

18. (a) Signature of funeral director M G Lorberg

(b) Address Cape Girardeau, MO

19. (a) Feb 26-44 (Date received local registrar) (b) Mrs W. L. Tomlinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 25 year 1944 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from 2/23/44, 19__, to 2/25/44, 19__; that I last saw her alive on 2/25/44, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Senility

Due to ✓

Due to ✓

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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? (Specify type of place)

While at work? ✓ (e) Means of injury ✓

23. Signature R. E. Lee MD (M. D. or other)

Address Illmo Mo Date signed 2/26/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 344-455
Date Filed 3-9-44

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 C. J. Lorberg

Licensed Embalmer No. 3810

P. O. Address Cape Girardeau, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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