

S. No. 2
M-8-43
v. 5-17-39
I X37823

29027

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 31 1946

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 7209

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Missouri Baptist Hospital
(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 Oscar Harrison Sanders

3. (b) If veteran, name war World War # 2

3. (c) Social Security 352-07-5643

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leona Sanders 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased February 8 1915
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>31</u>	<u>6</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Shot Fire

11. Industry or business Levy Work

12. Name Harrison Sanders

13. Birthplace Union County Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Mae Hill

15. Birthplace Cape County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Leona Sanders

(b) Address Anna, Ill.

17. (a) Removal (b) Date thereof 8-17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anna, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) Aug 19 1946 (b) J. F. Bredbeck
(Date of local filing) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Union 994

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

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

(e) Citizen of foreign country? _____ (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
year 1946 hour 6:10 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Congestion Duration
Relief Peritoneal Remedy
Trachea right tube
Due place, eyes and mouth
could not be determined

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) Open Vein

(b) Date of occurrence 8-17-46 136

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? no (Specify type of place) Means of injury remedy

23. Signature Patrick E. Taylor (M.D. or other)
Address Dep. coroner Date signed 8/19/46

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 W. W. Wilkinson
Licensed Embalmer No. 3575

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.