

FILED MAR 31 1947

318

1003

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: 5537 Oriole  
(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 Joseph Peter Sander

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 494-10-9588

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

6. (b) Name of husband or wife Catherine Sander 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 14 1889  
(Month) (Day) (Year)

8. AGE: Years 57 Months 6 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Fulton Iron Works

11. Industry or business 1259 Delaware

12. Name Frances Sander

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

14. Maiden name Maryann Kopera

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

16. (a) Informant Catherine Sander

(b) Address 5537 Oriole

17. (a) Burial (b) Date thereof 3/19/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery Central Und. Co

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

(b) Address \_\_\_\_\_

19. (a) MAR 17 1947 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5537 Oriole  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 15 year 1947 hour 11:30 minute AM

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 3-15-47, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 1 da  
Double Pneumonia 7 da  
Continued

22. If death was due to external causes, fill in the following:  
(c) 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? \_\_\_\_\_

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:  
(c) 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 J. J. Bredek (M. D. or other) \_\_\_\_\_  
Address 1875 Maple Date signed 3/17/47

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

MOTHER FATHER

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**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.....

*Henry W. Brammer*

Licensed Embalmer No..... *4200*

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.**