

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22621**

FILED JUN 30 1947

Registration District No. **318**

Primary Registration District No.

Registrar's No. **5978**

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 G. PHILLIPS, HOSP**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **36 YEARS**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **JAMES SANDERS JR.**
3. (b) If veteran, name war **2**
3. (c) Social Security No.

4. Sex **MALE** 5. Color or race **COL**
6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **25** years (Day) (Year)
7. Birth date of deceased **JULY 25 1911**
(Month) (Day) (Year)

8. AGE: Years **36** Months **10** Days **23**
If less than one day hr. min.

9. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABOR**

11. Industry or business

12. Name **JAMES SANDERS**
13. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **PEARL FRISBY**
15. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **SAMUEL FRISBY**
(b) Address **2948 CASS**

17. (a) **BURIAL** (b) Date thereof **JUNE 21 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **GREEN WOOD CEM**

18. (a) Signature of funeral director **F. A. GREEN**

(b) Address **2910 FRANKLIN AVE**

19. (a) **JUN 20 1947** (Date received local registrar)
J. J. Bredach (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **2702 Delmar**
21 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **18**
year **1947** hour **3** minute **30** A.M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 **Distention of stomach**
from a fatal wound of head
and left lung inflicted in
the streets of New Orleans
Johnson (La.) in front of
2704 Delmar around 3:30 PM
June 18, 1947

Other conditions: (Include pregnancy within 3 months of death)

Major findings: **168**
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) **Accidental homicide**
(b) Date of occurrence **June 18, 1947**
(c) Where did injury occur? **in front of**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Street

(Specify type of place) While at work? (c) Means of injury **6 above**

23. Signature **John L. & Hughes** (M.D. or other) **6/20/47**
Address _____ Date _____

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

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.....

J. A. Green

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

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.