

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28800

State File No.

FILED SEP 3 1947

Registration District No. 3/6

Primary Registration District No. 6075

Registrar's No. 300

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

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution:
Missouri State Hospital No. 4 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 yrs. 9 mos. 17
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MONROE G. SANDERS

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive About 1865 years
(Day) (Year)

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 82 hr. min.

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

10. Usual occupation Farming

11. Industry or business

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-47
(Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington, MO.

18. (a) Signature of funeral director Berl Miller Funeral Home

(b) Address Farmington, Missouri

19. (a) 9-3-47 (Date received local registrar)

(b) Ether Rudloff (Registrar's signature) 1947

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ripley 94

(c) City or town Unknown (County Farm) 0
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown 0
(If rural, give location)

das. No 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22, year 1947 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov. 5, 1935, 19 to August 22, 1947, 19 that I last saw h. im alive on August 22, 1947, 19 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days

Due to

Due to

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

Major findings: Chronic glomerulonephritis PHYSICIAN

Of autopsy: Bilateral Bronchi Pneumonia
Chronic glomerulonephritis

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 near about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Daniel Docton (M. D. or other) mo

Address Farmington Date signed 8/30/47

RECEIVED

Coroner Health Officer No. 4
District File Number 947-1151
Date Filed 9-8-47

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 _____
not embalmed _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Paul K. Dwyer
Licensed Embalmer No. 4120
P. O. Address Lansing, Mich

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.