

FILED SEP 1947

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 8428

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

1. PLACE OF DEATH:

(a) County: Barnes Hospital

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

(c) Name of hospital or institution: 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 20 days  
(Specify whether years, months or days)

In this community: \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 600

(c) City or town: St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No.: 5188 Cabanne Ave 9  
(If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: Edward Lewis Sanderson

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex: Male  5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Cora Sanderson

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: 1/3/1874  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
73	8	1	hr. min.

9. Birthplace: Stuen County, New York  
(City, town, or county) (State or foreign country)

10. Usual occupation: Electrician

11. Industry or business: Barnes Hospital

12. Name: John Sanderson

13. Birthplace: Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name: Elizabeth Longwall

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

16. (a) Informant: Cora Sanderson

(b) Address: 5188 Cabanne Ave

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof: 9/6/47  
(Month) (Day) (Year)

(c) Place: burial or cremation: Oak Grove Cemetery

18. (a) Signature of funeral director: Robert J. Ambruster, Inc

(b) Address: 6633 Clayton Road

19. (a) SEP 5 1947 (Date received local registrar)

(b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: September day: 4  
year: 1947 hour: 3:30 minute: a M.

21. I hereby certify that I attended the deceased from August 16, 1947 to September 4, 1947; that I last saw him alive on September 4, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of stomach with metastases

Due to: \_\_\_\_\_

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: As above

Duration

PHYSICIAN

Underline the cause of 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury: \_\_\_\_\_

23. Signature: F. Bradley (M. D. or other)

Address: Barnes Hospital Date signed: 9/7/47

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 \_\_\_\_\_  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

*Arnold W. Schene*

Licensed Embalmer No.

*3864*

P. O. Address

*St. Louis, Mo*

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.