

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14956

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>501</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Joseph</u> township)		c. LENGTH OF STAY (in this place) <u>9 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1523 messarie St.</u>				d. STREET ADDRESS (If rural, give location) <u>1523 messarie Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>David</u> c. (Last) <u>Saunders</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5 2 1949</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 3-1879</u>	9. AGE (in years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clergy</u>		11. BIRTHPLACE (State or foreign country) <u>Lexington - Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Not known</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>		14. NAME OF HUSBAND OR WIFE <u>Lottie Johnson Saunders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Daisy Hayes 1523 messarie St.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Insufficiency</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>April 26-49</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 26 49</u> , 19 <u>49</u> , to <u>May 6 1949</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>April 19 49</u> , and that death occurred at <u>3:15 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Trouton H. Saunders M.D.</u>				23b. ADDRESS <u>709 1/2 W. No. one</u>		23c. DATE SIGNED <u>May 3-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-5-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>May 5, 1949</u>		REGISTRAR'S SIGNATURE <u>G. B. Jenkins</u> 382		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. H. Alexander St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed

*Wm. H. Alexander*

Signed.....

Student Embalmer

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.