S. No. 300
Rev. 10.48

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

#92348

State File No. 11039

BIRTH NO. ____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2964

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 11 - 2527 N Spring

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): H
c. (Last): SANDS

4. DATE OF DEATH (Month) (Day) (Year): March 29th, 1950

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11-20-1867
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Racine Wis
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Alonzo Sands
13b. MOTHER'S MAIDEN NAME: Mary Blossick
14. NAME OF HUSBAND OR WIFE: Cecelia Sands Dec

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Joseph Becker
ADDRESS: 7410 Page

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of tongue — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid 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.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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): 141 X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/14/50, 19__, *to* 3/29/50, 19__, *that I last saw the deceased alive on* 3/29/50, 19__, *and that death occurred at* 6:40am *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William W. Carter MD
23b. ADDRESS: 1515 Lafayette Ave.,
23c. DATE SIGNED: 3/29/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-31-50
24c. NAME OF CEMETERY OR CREMATORY: Central Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Co

DATE REC'D BY LOCAL REG.: MAR 29 1950
REGISTRAR'S SIGNATURE: J. B. Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE: Sullivan Fun Dir
ADDRESS: 2840 Euclid

(Licensed Embalmer's Statement on Reverse Side)

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.

Student _____
Student Embalmer

Signed Robert L. Buckman

Licensed Embalmer No. 3553

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.