

FILED OCT 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36129

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>391</u>		PRIMARY REG. DIST. NO. <u>453</u> Registrar's No. <u>25</u>	
1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>			2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>R#1 Bell City, Mo Pike</u>)		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>R#1 Bell City, Mo</u>		1030
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Tinnie</u>		b. (Middle)		c. (Last) <u>Sanders</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>9 27 1951</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>5/9/91</u>		9. AGE (In years last birthday) <u>60</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Miss /</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Ben Latham</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Smith</u>	
14. NAME OF HUSBAND OR WIFE <u>John Sanders</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>John Sanders R#1 Bell City, Mo</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>None</u>		19. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>None</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Bronchial pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>None</u> ? DUE TO (c) <u>None</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</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) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Beaver City Stoddard Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>9/26</u> , 19 <u>51</u> , to <u>9/27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>9/25</u> , 19 <u>51</u> , and that death occurred at <u>2:15</u> p.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>M.D. in J. & M.D.</u>		23b. ADDRESS <u>Vanderburg Mo</u>		23c. DATE SIGNED <u>9/27/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/29/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Carpton Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>R#1 Sikeston, Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jones</u>		25. ADDRESS <u>Director Mo</u>	
DATE REC'D BY LOCAL REG. <u>10-3-51</u>		REGISTRAR'S SIGNATURE <u>Bessie Moore</u>		360	

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

RECEIVED

OCT 20 1951

DISTRICT HEALTH OFFICE No

File No.....

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.....

John Allerton

Licensed Embalmer No.

2941

P. O. Address

Spokane

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.