

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29694

State File No.
Registrar's No. 17

FILED AUG 18 1953

BIRTH NO. REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Mo b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'FALLON - Rural	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'Fallon Rural - Dardenne	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0920	

3. NAME OF DECEASED (Type or Print) a. (First) Flemond b. (Middle) Sanders c. (Last) Sanders			4. DATE OF DEATH (Month) (Day) (Year) Aug. 14-53		
-------------------------------------------------------------------------------------------------	--	--	--------------------------------------------------	--	--

5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH 4-29-1877		9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months	11. UNDER 1 HR. Hours	12. UNDER 1 MIN. Min.
-------------	------------------------	-------------------------------------------------------------------	----------------------------	--	------------------------------------	-------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Warren County Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA	
------------------------------------------------------------------------------------------------------	--	----------------------------------------------	--	---------------------------------------------------------------	--	----------------------------------	--

13a. FATHER'S NAME not known		13b. MOTHER'S MAIDEN NAME not known		14. NAME OF HUSBAND OR WIFE Mrs. Malinda Sanders			
------------------------------	--	-------------------------------------	--	--------------------------------------------------	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mabel Blackburn O'Fallon Mo.			
-------------------------------------------------------------------------------------------------------------	--	------------------------------	--	------------------------------------------------------------------------	--	--	--

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) Cerebral Apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis - DUE TO (c) Senility II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH	
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--	--	--	----------------------------------	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 334X				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Minute)		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 July 15, 1953, to Aug 14, 1953, that I last saw the deceased alive on Aug 14, 1953, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Doctor or title) C. Esch 0 Med		23b. ADDRESS T. M. M. O.		23c. DATE SIGNED Aug 18/53	
------------------------------------------------	--	--------------------------	--	----------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-17-53	24c. NAME OF CEMETERY OR CREMATORY Oak Grove	24d. LOCATION (City, town, or county) (State) St. Charles Mo.		
--------------------------------------------------	-------------------	----------------------------------------------	---------------------------------------------------------------	--	--

DATE REC'D BY LOCAL REG. Aug 16-53		REGISTRAR'S SIGNATURE E. A. Keithly 280		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wehde & Keithly O'Fallon Mo.	
------------------------------------	--	-----------------------------------------	--	-----------------------------------------------------------------------	--

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

AUG 19 1969

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
E. A. Entley

Signed.....
Student Embalmer

Licensed Embalmer No..... *822*

P. O. Address..... *Fallon 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.