

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **44456**

FILED JAN 5 1954

BIRTH NO. \_\_\_\_\_

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **11910**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri.</b> b. COUNTY <b>Franklin.</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <b>St. Clair,</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>-----</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>ARLIE</b> b. (Middle) <b>RUBEN</b> c. (Last) <b>SANDERS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>DECEMBER 16, 1953</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 22, 1877.</b>
9. AGE (In years last birthday) <b>76.</b>		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Minister</b>	11. BIRTHPLACE (City and State or Foreign Country) / <b>Bethel Springs, Tenn.</b>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Methodist</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Dudley Sanders</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Laughlin.</b>	14. NAME OF HUSBAND OR WIFE <b>Martha Sanders.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None.</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Martha Sanders St. Clair, Mo.</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MASSIVE GASTRO INTESTINAL BLEEDING</b>  ANTECEDENT CAUSES <b>DUE TO (b) ULCERATED POLYPS OF STOMACH</b>  <b>DUE TO (c)</b>  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>211X</b>			
22. I hereby certify that I attended the deceased from <b>12-16</b> , 19 <b>53</b> , to <b>12-16</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>12-16</b> , 19 <b>53</b> , and that death occurred at <b>5:10a. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>JR Prady</b>		23b. ADDRESS <b>M.D. BARNES HOSPITAL</b>	
23c. DATE SIGNED <b>12-16-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-17-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Lake Springs Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Dent County, Missouri.</b>	
DATE REC'D BY LOCAL REG. <b>DEC 17 1953</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington.</b>	

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

JAN 12 1954

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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.....  
Signature of Student Embalmer

Signed *Robert M Murray*.....

Licensed Embalmer No. *37490*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.