S. No. 300
v. 10.48

FILED JAN 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2180

BIRTH NO. _____ REG. DIST. NO. 264 PRIMARY REG. DIST. NO. 5891 Registrar's No. 1

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

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Ozark
c. CITY OR TOWN: Gainesville
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 0770

3. NAME OF DECEASED (Type or Print): a. (First) Ida b. (Middle) Caldena c. (Last) Sanders
4. DATE OF DEATH (Month) 1 (Day) 3 (Year) 57
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3-15-1878
9. AGE (In years last birthday): 78 | 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (City and State or Foreign Country): Ark.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Frank Thompson
13b. MOTHER'S MAIDEN NAME: Nancy Barger
14. NAME OF HUSBAND OR WIFE: Otis Sanders
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Ola. Grooms ADDRESS: Springfield Mo.

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

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)
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* 12-31, 1956 *to* 1-3, 1957, *that I last saw the deceased alive on* 1-2, 1957, *and that death occurred at* 2:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: M. J. Hoerman (Degree or title) DO
23b. ADDRESS: Gainesville Mo
23c. DATE SIGNED: 1-4-57

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-5-57
24c. NAME OF CEMETERY OR CREMATORY: Gainesville
24d. LOCATION (City, town, or county) (State): Gainesville Mo.

DATE REC'D BY LOCAL REG.: 1-7-57
REGISTRAR'S SIGNATURE: Thena Mahan
25. FUNERAL DIRECTOR'S SIGNATURE: Clinkingbeard ADDRESS: Gainesville, Mo.

(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 embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John R. Elsey

Licensed Embalmer No. 4885

P. O. Address Gainesville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail 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.