

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 21 1957

9404

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 95

Health,
& Welfare
Public
Service

300
1-56

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>614 North Walnut</u> ⁰⁰⁴¹ 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeths Hosp</u> Length of stay in lb		d. STREET ADDRESS <u>Vandalia</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arch</u> Middle <u>Jordan</u> Last <u>Sanderson</u>		4. DATE OF DEATH <u>March 2, 1957</u> Month <u>March</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Male</u> 0	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2, 1887</u>
9. AGE (In years last birt day) <u>69</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>	11. BIRTHPLACE (City and state or country) <u>Mexico, Missouri</u> 0
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>George Sanderson</u>	
14. MOTHER'S MAIDEN NAME <u>Nannie Simpson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>493-03-1749</u>		17. INFORMANT <u>Mrs Arch Sanderson, Vandalia, Mo</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from <u>5-12-54</u> to <u>3-2-57</u> and last saw her/him alive on <u>3-2-57</u> Death occurred at <u>10:25 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>0</u>		22b. ADDRESS <u>M. D. 180 N. Sixth, Hannibal, Mo.</u>	
22c. DATE SIGNED <u>3-12-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar 4, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Vandalia, Missouri</u>	
24. FUNERAL DIRECTOR <u>William B Waters</u> ADDRESS <u>Vandalia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-13-57</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAR 20 1957
MARION CO. HEALTH DEPT.
DATE FILED MAR 20 1957

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 *William B. Waters*

Licensed Embalmer No. *4164*

P. O. Address *Vandalia, 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.