

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29979
State File No. _____
7508
Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before a. STATE Illinois b. COUNTY Marian <input checked="" type="checkbox"/> admission)			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 9 days		c. CITY OR TOWN Salem.		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 Barnes Hospital				STREET ADDRESS (If rural, give location) 812 1/2			
3. NAME OF DECEASED (Type or Print) BERTHA SANDERS			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH August 12 1957 (Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Nov. 20, 1883	
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		11. BIRTHPLACE (City and State or Foreign Country) Chaffee, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Walter Brown		13b. MOTHER'S MAIDEN NAME Eliza Gossey		14. NAME OF HUSBAND OR WIFE Thomas Sanders, deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME NO. ADDRESS Mrs. Ellen Franklin, 1417 Clinton, St. Louis			
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.		19. MAJOR FINDINGS OF OPERATION about 6:30 pm August 3rd 1957.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. INCIDENT SUICIDE Accidental		21b. PLACE OF INJURY (e.g., In or about home, farm, factory, post office, etc.) 32 Street		21c. (CITY, TOWN OR TOWNSHIP) COUNTY (STATE) 32 Salem, Illinois			
21d. TIME OF INJURY 8 3 57 6 pm		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 47 E 812 1/2			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:20A m., from the causes and on the date stated above.							
23a. SIGNATURE Patrick P. Taylor				23b. ADDRESS 1500 Clark		23c. DATE SIGNED 8.12.57.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 14, 1957		24c. NAME OF CEMETERY OR CREMATORY local		24d. LOCATION (City, town, or county) (State) Tuka, Illinois	
DATE REC'D BY LOCAL REG. AUG 12 57		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS R. Kurrus, E. St. Louis, Ill			

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 embalmed by me, or by Student Embalmer No. working under my personal supervision..

Student Signed
Signature of Student Embalmer

Not Embalmed

R. Kurumaji

Licensed Embalmer No. *316*
P. O. Address *St. Louis*

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.