

FILED SEP 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31031

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 226

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton 2</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #1</b>		Length of stay in lb <b>7 months</b>	d. STREET ADDRESS (If outside, give location) <b>Route 3, Box 341</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NANCY</b> Middle <b>SANDERS</b> Last <b>SANDERS</b>			4. DATE OF DEATH Month <b>9-</b> Day <b>11</b> Year <b>1957</b>
5. SEX <b>Female 3</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1904</b>
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Tennessee /</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Tom Churthurs</b>	
14. MOTHER'S MAIDEN NAME <b>Laura Pruitt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unk.</b>	
16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT Address <b>State Hospital No. 1; Fulton, Missouri</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrae Hemorrhage</b> DUE TO (b) <b>Inanition</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>331X</b>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <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.) <b>State Hosp. #1</b>	
20f. CITY, TOWN, OR LOCATION <b>State Hosp. #1</b>		COUNTY <b>Fulton</b> STATE <b>Mo</b>	
21. Attended the deceased from <b>2-8-57</b> to <b>9-11-57</b> Death occurred at <b>3:20 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>T. D. McCarthy M.D.</b>		22b. ADDRESS <b>State Hosp #1 Fulton Mo</b>	
22c. DATE SIGNED <b>11 Sept 57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>Sept. 16, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Charleston, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>L. R. Sparks</b> ADDRESS <b>Charleston, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 16, 1957</b>	
26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>			

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Edward H. Puffin*

Licensed Embalmer No. 502  
2501 Poplar St.  
P. O. Address Cairo, Ill

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