

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3876

Health, Welfare
Public
Service

300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 27 1958

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 115

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR <u>CLAYTON</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Webster Groves</u> Inside Limits <u>45970</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u> Length of stay in 1b <u>6 DAYS</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>900 BELL</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ardie</u> Middle <u>Sanderford</u> Last <u>Sanderford</u>			4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 1902</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	11. BIRTHPLACE (City and state or country) <u>Trenton Tenn</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jim James</u>			14. MOTHER'S MAIDEN NAME <u>Jennie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Father Sanderford 900 BELL</u>		

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>Thrombosis of Right Internal Carotid Artery</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Atherosclerosis.</u>	
	DUE TO (c) <u>332X</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute Pyelitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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 <u> </u> Month, Day, Year a. m. <u> </u> p. m. <u> </u>	

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
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21. I attended the deceased from 1-4-58 to 1-10-58 and last saw her alive on 1-10-58
Death occurred at 1155 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degrees or title) <u>Gene M. Rose M.D.</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>1-10-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/14/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL</u>	23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BARRACKS, Mo.</u>
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24. FUNERAL DIRECTOR <u>J. H. Randle</u>	ADDRESS <u>PO BOX 3133 BELL</u>	25. DATE RECD. BY LOCAL REG. <u>1-14-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donohue</u>
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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 *Esther N. Harris*

Licensed Embalmer No. *417*
P. O. Address *4181 7/2*

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.