

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017080  
STATE FILE NUMBER

FILED APR 29 1958

Registration District No. 354 Primary Registration District No. 6199 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <u>Wright Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn Grove</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mtn Grove Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton Sup.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>107th</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matilda C. Sanders</u>			4. DATE OF DEATH Month Day Year <u>Apr 15, 1958</u>
5. SEX <u>Female</u>	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>Mar 15, 1887</u>
9. AGE (In years last birthday) <u>76</u>		10. UNDER 1 YEAR Months Days <u>10</u>	11. UNDER 24 HRS. Hours Min. <u>76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Texas Co. Mo.</u>	11. BIRTHPLACE (City and state or country) <u>Texas Co. Mo. U.S.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>James Nevels</u>		13b. MOTHER'S MAIDEN NAME <u>Michel Sanders</u>	
14. NAME OF HUSBAND OR WIFE <u>Arthur Sanders</u>		14. NAME OF HUSBAND OR WIFE <u>Arthur Sanders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and branch of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Arthur Sanders</u>		Address <u>Mtn Grove</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>Medullary Paralysis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombotic Cerebrovascular Cerebral Hemorrhage</u>			<u>72 Hours</u>
DUE TO (c) <u>Arteriosclerosis</u>			<u>331 X undetermined</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"/>		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.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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>Feb 1955</u> to <u>April 15 1958</u> and last saw her alive on <u>April 15, 1958</u> Death occurred at <u>6:00 Am.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Richard E. Mitchell D.O.</u>		22b. ADDRESS <u>Mtn Grove, Mo.</u>	
22c. DATE SIGNED <u>4-18-58</u>		22c. DATE SIGNED <u>4-18-58</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		23b. DATE <u>4-17-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		23d. LOCATION (City, town, or county) (State) <u>Mtn Grove, Mo.</u>	
24. FUNERAL DIRECTOR <u>Thable W. Wilder</u>		25. DATE RECD. BY LOCAL REG. <u>4-24-58</u>	
ADDRESS <u>Mtn Grove, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Gaynell Cunningham</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Frank Grable* .....

Licensed Embalmer No. *450* .....  
P. O. Address *1111 1st St, N.W.* .....

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.