

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-19199A

STATE FILE NUMBER

FILED MAY 27 1958

Registration District No. 234

Primary Registration District No. 5814

Registrar's No. 17

S. 300  
1-57

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MORGAN</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>MORGAN</b>                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>BUFFALO Twp.</b>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <b>BUFFALO Twp</b> <b>0710</b>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>12 MILES S. STOVER</b>   |                                  | Length of stay in 1b<br><b>17 YRS</b>   | d. STREET ADDRESS (If outside, give location)<br><b>12 MILES SOUTH STOVER</b>                     |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>MATILDA ANN SANDERS</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>MAY 14 1958</b>  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 17 1863</b>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 9b. KIND OF BUSINESS OR INDUSTRY<br><b>FARM</b>   | 9c. AGE (In years last birthday) Months Days<br><b>94 11 27</b>                                   |
| 10a. FATHER'S NAME<br><b>HENRY CAMPBELL</b>  |                                  | 10b. MOTHER'S MAIDEN NAME<br><b>SUSAN OWENS</b>   | 10c. NAME OF HUSBAND OR WIFE<br><b>RUBEN B. SANDERS</b>   |
| 11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                  | 12. SOCIAL SECURITY NO.<br><b>NONE</b>  | 13. INFORMANT Address<br><b>MRS. OSCAR GERHART STOVER MO</b>                                      |
| 14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Wks.</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |                                  |   | <b>4341A</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Inactive fibrotic tuberculosis</b>   |                                  |   | 15. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 16a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                                  | 16b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 17c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                                  | 17d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 17e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 17f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 18. I attended the deceased from <b>May 1 1958</b> to <b>May 14 1958</b> and last saw her alive on <b>May 12 1958</b><br>Death occurred at <b>3:15 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 19a. SIGNATURE (Degree or title)<br><b>Jack Gunnard</b>  |                                  | 19b. ADDRESS<br><b>Versailles, Mo.</b>  |   |
| 19c. DATE SIGNED<br><b>5:16:58</b>   |                                  | 19d. DATE SIGNED  |   |
| 20a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIED</b>   |                                  | 20b. DATE<br><b>MAY 17 1958</b>   |   |
| 20c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PAUL'S CEMETERY</b>   |                                  | 20d. LOCATION (City, town, or county) (State)<br><b>MORGAN COUNTY MO</b>  |   |
| 21. FUNERAL DIRECTOR ADDRESS<br><b>J. K. Stevinson Stover Mo</b>   |                                  | 21. DATE RECD. BY LOCAL REG.<br><b>May 20-1958</b>  |   |
| 21. REGISTRAR'S SIGNATURE<br><b>Thos. Kasperiger</b>   |                                  | 21. REGISTRAR'S SIGNATURE   |   |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. H. Stevenson* .....

Licensed Embalmer No. *4093*  
P. O. Address *Stover 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.