

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035716

STATE FILE NUMBER

FILED NOV 10 1958

Registration District No.

53

Primary Registration District No.

3010

Registrar's No.

515

5. 300  
1-57  
0

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <i>Missouri</i> b. COUNTY <i>Scott</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cape Girardeau</i>		c. CITY OR TOWN <i>Illmo</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Cape Girardeau Hosp.</i>		d. STREET ADDRESS (If outside, give location) <i>1000</i>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHN HENRY SANDER</i>			4. DATE OF DEATH Month Day Year <i>10 - 10 - 58</i>			
--	--	--	---	--	--	--

5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-10-58</i>	9. AGE (In years last birthday) <i>0</i>	FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	-------------------------------------	---	------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Cape Girardeau, Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
--	-----------------------------------	---	---

13a. FATHER'S NAME <i>Billy G. Sander</i>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
--	---------------------------	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Billy G. Sander</i>	Address <i>Illmo, Mo</i>
---	--	---	-----------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fetal Anoxia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 hrs.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Atelectasis</i>		<i>11 hrs.</i>
	DUE TO (c) <i>prematurity wt. 3 lb. 48 gr.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>7625</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input 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 a.m. Month, Day, Year 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--	---	--	------------------------------	--------	-------

21. I attended the deceased from <i>10-10-58</i> to <i>10-10-58</i> and last saw him alive on <i>10-10-58</i> Death occurred at <i>8:30 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>H. N. Schmeyer, D.O.</i>	22b. ADDRESS <i>Chaffee, Missouri</i>	22c. DATE SIGNED <i>10/11/58</i>
---	--	-------------------------------------

23a. BURIAL, CREMATION, GENEROVAL (Specify)	23b. DATE <i>10-11-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Righter Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Illmo, Missouri</i>
---	------------------------------	---	---

24. FUNERAL DIRECTOR <i>Bioplinghoff Funeral Home</i>	ADDRESS <i>Illmo</i>	25. DATE RECD. BY LOCAL REG. <i>Nov 4, 1958</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Homer Cooper</i>
--	-------------------------	--	---

All diseases in Part I must be causally related. No symptoms were mentioned to which symptoms were listed.

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 .....

Licensed Embalmer No.....

P. O. Address.....

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.

*Not Embalmed*