

Health,  
L. Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042887  
STATE FILE NUMBER

FILED DEC 10 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3143

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		c. CITY OR TOWN <b>Normandy 4700</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7006 Woodrow</b>		d. STREET ADDRESS <b>7006 Woodrow</b>	
Length of stay in lb <b>years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>DALE</b> Last <b>SANDERS</b>			4. DATE OF DEATH Month <b>Nov</b> Day <b>30</b> Year <b>1958</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 23, 1934</b>	9. AGE (In years last birthday) <b>24</b>	10. FUNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>warehouseman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Henry G Sanders</b>	13b. MOTHER'S MAIDEN NAME <b>Elsie Marsh</b>	14. NAME OF HUSBAND OR WIFE <b>single</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	16. SOCIAL SECURITY NO. <b>489-34r-5884</b>	17. INFORMANT Address <b>John Walker 3124 Allen St. Louis, Mo.</b>
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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>Unknown natural causes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
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"/> <b>2</b>

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.) <b>7954</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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 <b>St. Louis</b>	COUNTY _____	STATE _____
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **1:44 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Herbert R. Domke MD</b>	22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>	22c. DATE SIGNED <b>12-5-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	23b. DATE <b>Dec 2, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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24. FUNERAL DIRECTOR <b>C.R. Lupton and sons</b>	ADDRESS <b>7233 Delamr</b>	25. DATE RECD. BY LOCAL REG. <b>12-1-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Domke, MD</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

4001  
300  
1-57

County Hospital

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 *Arnold W. Schoene* .....

Licensed Embalmer No. *3864* .....  
P. O. Address *St. Louis, 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.