Health, Welfare Public Service

300 1
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-043116
STATE FILE NUMBER

FILED DEC 3 1958 Registration District No. 375 Primary Registration District No. 62 Registrar's No.

1. PLACE OF DEATH
a. COUNTY: WRIGHT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: HART TOWNSHIP — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 8 mi. NW. NORWOOD — Length of stay in Hospital: 10 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: WRIGHT
c. CITY OR TOWN: NORWOOD — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 8 mi N.W. — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: MARION Middle: HARRY Last: SANDERS
4. DATE OF DEATH: Month 11 Day 21 Year 58
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-9-1891
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months — Days 12 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (City and state or country): WRIGHT Co. MO
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: JOHN SANDERS
13b. MOTHER'S MAIDEN NAME: MATILDA SHIELDS
14. NAME OF HUSBAND OR WIFE: Margaret SANDERS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Kenneth Long — Address: NORWOOD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypo Static Pneumonia	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Stomach Ulcers + Hemorrhage	6 mos
DUE TO (c)	Hemorrhage	2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 5400

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 June 1 1958 to 11-21-58 and last saw her/him alive on 11-21-58
Death occurred at 7:P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: E. Worthington M.D. (Degree or title)
22b. ADDRESS: Hartville Mo
22c. DATE SIGNED: 11-28-58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 11-24-58
23c. NAME OF CEMETERY OR CREMATORY: OAK GROVE
23d. LOCATION (City, town, or county) (State): WRIGHT Co MO.

24. FUNERAL DIRECTOR: John Simpson — ADDRESS: Hartville
25. DATE RECD. BY LOCAL REG.: 12/2/58
26. REGISTRAR'S SIGNATURE: Bonnie J. Jones

(Licensed Embalmer's Statement on Reverse Side)

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 George Stapp

Licensed Embalmer No. 3161

P. O. Address [illegible]

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.