

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014138

FILED APR 17 1959 Registration District No. 279 Primary Registration District No. 3043 STATE FILE NUMBER Registrar's No. 106

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>308 North Main</u>		d. STREET ADDRESS (If outside, give location) <u>308 North Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BRATON</u> Last <u>SANDERS</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 26, 1909</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Holiday, Montana</u>	11. BIRTHPLACE (City and state or country) <u>Montana, Montana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
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13a. FATHER'S NAME <u>E. J. Sanders</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret L. Ferrell</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>es W W 2 Korean</u>	16. SOCIAL SECURITY NO. <u>491 14 969</u>	17. INFORMANT <u>Mrs. Vilave Murray Hannibal Missouri</u>	Address
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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) <u>Hemorrhage from radial artery, rt.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-10 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Razor blade wound of radial artery</u>	<u>5-10 min</u>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>977X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Rolled up right sleeve, cut arm below antecubital</u>
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20c. TIME OF INJURY Hour <u>9</u> a.m. <u>4 12 59</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>	COUNTY <u>Marion</u>	STATE <u>Mo</u>
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>9</u> <u>a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Henry Sweet J. M.D. Coroner</u>	(Degree or title) <u>3</u>	22b. ADDRESS <u>Hannibal Mo</u>	22c. DATE SIGNED <u>4/14/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/15/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Monroe County Missouri</u>
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24. FUNERAL DIRECTOR <u>W. Crawford Smith Hannibal Missouri</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4/14/59</u>	26. REGISTRAR'S SIGNATURE <u>H. E. Lucke By W. C. Fisher</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
-57

DATE FILED

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 *W. Crawford Smith*

Licensed Embalmer No. 7814

P. O. Address Hannibal Missouri

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.