

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025674

FILED VS AUG 11 1959

Registration District No. 157 Primary Registration District No. 4248 Registrar's No. 136

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sarcoxie</u>		Length of stay in 1b <u>2 yrs</u>	c. CITY OR TOWN <u>Sarcoxie</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>Same</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>no</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Clayton G. Sanders</u>			4. DATE OF DEATH Month Day Year <u>Aug 4 - 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Wh</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>2-4-1903</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>deade co</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Walter Sanders</u>		13b. MOTHER'S MAIDEN NAME <u>Lulu Copeland</u>		14. NAME OF HUSBAND OR WIFE <u>Eva Sanders</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT (Address) <u>Eva Sanders Sarcoxie Mo</u>		

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) <u>Circulatory Failure</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute and Chronic Coronary Thromboses 2 years</u>	
	DUE TO (c) <u>Arteriosclerosis</u>	<u>Unknown</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. p.m. Month, Day, Year		

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 COUNTY STATE
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21. I attended the deceased from 2-3-57 to 8-4-59 and last saw her/him alive on 6-13-59.
Death occurred at 10:50 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. Woodstrom M.D.</u>	22b. ADDRESS <u>Sarcoxie Mo</u>	22c. DATE SIGNED <u>8-5-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cen</u>	23d. LOCATION (City, town, or county) (State) <u>Sarcoxie Mo</u>
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24. FUNERAL DIRECTOR <u>Lachmon Sam Sarcoxie Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Aug 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ernie E. Strait, Deputy</u>
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MEDICAL CERTIFICATION BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm H Jackson

Licensed Embalmer No. 355

P. O. Address Savannah

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.