

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT. 6 1959 53

3009

345

59-031717

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Burd Twp.</u>		Length of stay in 1b <u>99 yrs.</u>	c. CITY OR TOWN <u>Jackson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson R#2</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR#2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>John</u> Last <u>Sander</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/1860</u>	9. AGE (last birthday) <u>99</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Jackson, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Henry J. Sander</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Macke</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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 <u>Henry Sander</u> Address <u>Cape Girardeau, 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>Arterial fibrillation, congestive failure</u>			<u>2 1/2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		<u>indefinite</u>
	DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>indefinite</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

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 <u></u> a.m. <u></u> Month, Day, Year <u></u>		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	

21. I attended the deceased from 9-1-59 to 9-27-59 and last saw her him alive on 9-18-59
 Death occurred at 11:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. R. Cochran</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Cape Girardeau, Mo</u>	22c. DATE SIGNED <u>9-28-59</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/29/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Methodist</u>	23d. LOCATION (City, town, or county) (State) <u>Gordonville Mo.</u>
24. FUNERAL DIRECTOR <u>McCombs</u> ADDRESS <u>Jackson, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 30-59</u>	26. REGISTRAR'S SIGNATURE <u>Irene Kuster</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 B. A. Meyer

Licensed Embalmer No. 3051

P. O. Address Jackson, 9

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.