

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 17 1960

60-013159

2 2641

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>5 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS. ADMIN. HOSPT.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2929 CASS</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>NMI</b> Last <b>SANDERS</b>	4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1960</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>DECATUR, ALA.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>OLIVER SANDERS</b>	13b. MOTHER'S MAIDEN NAME <b>MARY WHITFIELD</b>	14. NAME OF HUSBAND OR WIFE <b>MARY SANDERS</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>YES WW I</b>	16. SOCIAL SECURITY NO. <b>425-22-7830</b>	17. INFORMANT <b>MARY SANDERS 2929 CASS, 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:		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b>		YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	
	DUE TO (c) <b>420.0</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BRONCHOPNEUMONIA, CEREBRAL HEMORRHAGE</b>	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 checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ m. _____ p.m. _____	Month, Day, Year
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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. **VA** attended the deceased from **2/28/60** to **3/4/60** and last saw him **live** on **3/4/60**  
Death occurred at **2:20 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>ROBERT STROUB</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>3/4/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-8-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sheffield, Alabama</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>G. Wade Granberry</b> ADDRESS <b>4202 Finney Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 7 1960</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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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

*Edward A. Flynn*

Licensed Embalmer No. 4444

P. O. Address 4202 Fin

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