

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040900

FILED VS NOV 28 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 338

1. PLACE OF DEATH a. COUNTY <b>ADAIR</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>KNOX.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KIRKSVILLE</b>		Length of stay in 1b <b>38 Days</b>	c. CITY OR TOWN <b>HURDLAND</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Laughlin Hospital &amp; Clinic</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>SARAH SANDERS</b>	First Middle Last	4. DATE OF DEATH <b>NOVEMBER 19, 1960</b>	Month Day Year
---	-------------------	--	----------------

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/78</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	-----------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done or kind of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>QUEEN CITY, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	-----------------------------------	---	--

13a. FATHER'S NAME <b>MARTIN LEGRAND</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH VAUGHN</b>	14. NAME OF HUSBAND OR WIFE <b>ORVILLE SANDERS</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Mrs. Russell Gelbach</b>	Address <b>Hurdland, Mo</b>
--	--	--	--------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis; Diabetes Mellitus</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
---	--	--

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
---	--	--	--

21. I attended the deceased from <b>10-13-60</b> to <b>11-19-60</b> and last saw <sup>her</sup> him alive on <b>11-19-60</b> Death occurred at <b>8:45 pm.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>Richard D. Valuckoo</b> (Degree or title)	22b. ADDRESS <b>Laughlin Hospital</b>	22c. DATE SIGNED <b>11-21-60</b>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>22 Nov '60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hills Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville, Missouri</b>
--	--------------------------------	---	--

24. FUNERAL DIRECTOR <b>HUDSON-RIMER FUNFRAL HOME</b>	ADDRESS <b>Edina, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>11-23-1960</b>	26. REGISTRAR'S SIGNATURE <b>Maria W. Rathff</b>
--	-----------------------------	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RICHARD P. VALUEK, D.O.

**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 AGP

Licensed Embalmer No. 504

P. O. Address Edinburg

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.