

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014385  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1003

**FILED APR 11 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Winchester</u>		Length of stay in 1b <u>5 yrs.</u>	c. CITY OR TOWN <u>Castlewood</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>Manchester Nurs. Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>643 Castle Cliff</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>W.</u> Last <u>SANDERS</u>			4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1963</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (last birthday) <u>64</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Anton Weixel.</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Herman Sanders</u>		17. INFORMANT Address <u>52 Herman Sanders, 643 Castle Cliff, Ballwin, Mo.</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>52</u>	
18. CAUSE OF DEATH (Enter only one cause per item for each part) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Sclerosis</u> DUE TO (c) <u>General Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Don't know</u> <u>Don't know</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes, Previous Hemiplegia</u>			PART-III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 checked="" 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 <u>Aug. 17th, 1958</u> to <u>March 22, 1963</u> and last saw <sup>her</sup> him alive on <u>March 22, 1963</u> Death occurred at <u>8:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ralph W. Zaffey, M.D.</u>		22b. ADDRESS <u>Box 122, Manchester, Mo</u>	22c. DATE SIGNED <u>3-23-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3/25/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery, St. Louis, Mo.</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> (State)
24. FUNERAL DIRECTOR <u>Schrader Funeral Home, Ballwin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-24-63</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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

*Richard Bopp*

Licensed Embalmer No.

*4584*

P. O. Address

*Bellewin, Mo.*

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.