. S. No. 2
M—8-43
v. 5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7039

Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 282

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Flat River, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Flat River, Mo 94
(If outside city or town limits, write "RURAL")
(d) Street No. Roosevelt
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs. Rosa A. Saak
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White Cauc.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Otto Saak
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased January (Month) 25 (Day) 1945 (Year)

8. AGE:	Years	Months	Days	If less than one day
	50	3	23.	hr. min.

9. Birthplace St Genevieve Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Mr Henry Alexander
13. Birthplace Tennessee (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Miss Diay Hammers
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Mary Lewis Mr Otto Saak
(b) Address Roosevelt St Flat River
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla St Louis Mo
18. (a) Signature of funeral director Alvin W. Hood
(b) Address 303 Crane St. Flat River Mo.
19. (a) 1-28-45 (Date received local registrar) (b) Torres Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25
year 1945 hour 10 P.M. minute M.
21. I hereby certify that I attended the deceased from
, 19, to JAN. 23, 1945
that I last saw her alive on JAN 25, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ~~Coronary acute occlusion~~	
Acute coronary Occlusion	45 Min
Due to Arteriosclerosis (coronary)	one year
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

94a

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature W A Rohlfing (M. D. or other) DO
Address Flat River Date signed 1/27/45

1573 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 245-258

Date Filed 2-20-45

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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flat River, Mo 303 Ce

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 this body is not embalmed, fact should be so stated above.