

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE STATE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11608**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2213**

1. PLACE OF DEATH:  
(a) County **St. Louis, Missouri**  
(b) City or town **St. Louis, Missouri**  
(c) Name of hospital or institution: **St. Louis City Hospital - Max C. Starkloff**  
(d) Length of stay: In hospital or institution **3 weeks**  
In this community **D** years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis 96**  
(c) City or town **Springfield Wellston**  
(d) Street No. **6756a Page Memorial**  
(e) Citizen of foreign country? **1** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **JOSEPH SABADAS**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **5th** year **1946** hour **3:28** minute **P** M.  
21. I hereby certify that I attended the deceased from **2/8/46** to **3/5/46** that I last saw him alive on **3/5/46** and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **widowed**  
6. (c) Age of husband or wife if alive **18, 1877** years  
7. Birth date of deceased **Sept. 18, 1877** (Month) (Day) (Year)

Immediate cause of death **Bronchopneumonia**  
Due to \_\_\_\_\_  
Due to **309 General paresis**  
Other conditions **General paresis**  
Major findings: Of operations \_\_\_\_\_  
Of autopsy **Bronchopneumonia**

8. AGE: Years **68** Months **9** Days **17** If less than one day hr. min.  
9. Birthplace **Penn.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Maintenance man**

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

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name **Unknown**  
13. Birthplace **Unknown**  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
16. (a) Informant **Mrs. Suzanne Surkamp**  
(b) Address **6756a Page**  
17. (a) **burial** (b) Date thereof **3-7-46**  
(c) Place: burial or cremation **Zion Cemetery**  
18. (a) Signature of funeral director **Alexander & Sons**  
(b) Address **6175 Delmar Blvd.**  
19. (a) **MAR 6 1946** (b) **J. Z. Bredeck** (Registrar's signature)

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? \_\_\_\_\_  
While at work \_\_\_\_\_  
23. Signature **Robert L. Hubbell** M. D.  
Address **1515 Lafayette** signed **3/6/46**

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

Vertical stamp on left edge

30  
17  
9

Vertical stamp on left edge

*Embalmer separate Cert filed*

MAR 6 1946

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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**