

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14120

#24815

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

State File No. 3940  
Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri.		a. STATE Missouri b. COUNTY	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 1723 So. 8th St.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) JOSEPH b. (Middle) SAAKE c. (Last)			April 30, 1949
5. SEX M <input checked="" type="checkbox"/> W <input type="checkbox"/>	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 4, 1886
9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY XX	9. AGE (In years last birthday) Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Anton Saake		13b. MOTHER'S MAIDEN NAME Katty Huning	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No XX		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Julia Batts, 1723 So. 8th St.,
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tbc		INTERVAL BETWEEN ONSET AND DEATH Jan-ado	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
DUE TO (b) Congestive Heart Failure			
DUE TO (c) Arteriosclerosis			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 18	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? d02 X	
22. I hereby certify that I attended the deceased from 4/23/49, to 4/30/49, 19, that I last saw the deceased alive on 4/30/49, and that death occurred at 6:25 P.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John W. Murphy M.D.		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 5/2/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/3/49	24c. NAME OF CEMETERY OR CREMATORY St. Matthew's Cemetery, St. Louis, Mo.	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 2 REGISTRAR J. B. Pasater		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacka-Heldrich Und. Co., 3634 Harris	

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

**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 .....  
Student Embalmer

Signed Delix J. Krispin

Licensed Embalmer No. 3497

P. O. Address 3634 Travis

**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.