

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26115

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 981

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 5 days		d. STREET ADDRESS (If rural, give location) R. R. # 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Pearl	b. (Middle) J.	c. (Last) Sagers	4. DATE OF DEATH (Month) (Day) (Year) August 30, 1950
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 9-27-1880	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper	10b. KIND OF BUSINESS OR INDUSTRY homes	11. BIRTHPLACE (State or foreign country) Andrew County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James H. Sagers	13b. MOTHER'S MAIDEN NAME Martha Blaine	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME P. O. Sagers, St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolization		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension C. V. disease		
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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)
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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?
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22. I hereby certify that I attended the deceased from 8-25 ¹⁹⁵⁰ to 8-30, 1950, that I last saw the deceased alive on 8-30, 1950, and that death occurred at 11:40 m., from the causes and on the date stated above.

23a. SIGNATURE Leota C. Benson, M.D. (Degree or title)	23b. ADDRESS 510 Corbin Bldg.	23c. DATE SIGNED 9/1/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 9/2/50	24c. NAME OF CEMETERY OR CREMATORY Long Branch Cemetery	24d. LOCATION (City, town, or county) (State) Long Branch, Mo.
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DATE REC'D BY LOCAL REG. Sept. 2, 1950	REGISTRAR'S SIGNATURE E. G. Jenkins 382	FUNERAL DIRECTOR'S SIGNATURE Leota C. Benson ADDRESS St. Joseph, Mo.
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

William Spalding

Licensed Embalmer No. *4535*

P. O. Address *319 S. 11th St. Spokane*

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.