

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 6607

Registrar's No. 1764

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 6607			
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>60 Yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2019			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>416 Wilmington Avenue</u>			/ d. STREET ADDRESS (If rural, give location) <u>416 Wilmington Avenue</u>						
3. NAME OF DECEASED (Type or Print) <u>Lena Sawyer</u>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 21, 1951</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>March 6, 1879</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Menden, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Cafeteria</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mfgr. Diesel engines</u>			13a. FATHER'S NAME <u>Herman Tielkemeier</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa Weihe</u>	
14. NAME OF HUSBAND OR WIFE <u>Jacob Sawyer</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>493-10-0720</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Oliver Sawyer, 6300a Lenox Avenue</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary, Clean</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis, Hard Clean</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 yrs</u>	
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) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>153X</u>							
22. I hereby certify that I attended the deceased from <u>March, 1949</u> , to <u>Feb. 10, 1951</u> , that I last saw the deceased alive on <u>Feb. 10, 1951</u> ; and that death occurred at <u>5:30A.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>W. J. JOURNAS</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>539 No. Grand, St. Louis 3, Mo.</u>			23c. DATE SIGNED <u>2/22/51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 23, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Old Pickers Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>FEB 23 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Koster</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u>				

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

Dr. Christopher Vournas
Humboldt Bldg.
539 No. Grand

NE 0136

NO HOURS WEDNESDAY

1:30 to 3:30 Thursday

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 _____

Max L Warfel

Signed.....
Student Embalmer

Licensed Embalmer No. 4170

P. O. Address 1936 St Louis Ave

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.