

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10529

State File No.

FILED MAR 24 1952

BIRTH/NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2038**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <i>St. Louis Mo</i>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1000 Leavel</i>		d. STREET ADDRESS (If rural, give location) <i>1869 So. 10th St.</i>	
3. NAME OF DECEASED a. (First) <i>Thomas</i> b. (Middle) <i>Edward</i> c. (Last) <i>Sadler</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 19, 1952</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>About 1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unavailable</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>England</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13a. FATHER'S NAME <i>Unknown</i>	
13b. MOTHER'S MAIDEN NAME <i>Unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Lillie I.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT'S SIGNATURE OR NAME <i>Thomas M. Brady, P.A.</i>		ADDRESS <i>St. Louis, Mo.</i>	
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) ANTECEDENT CAUSES DUE TO (b) <i>Lobar Pneumonia</i> DUE TO (c) <i>right upper and lower lobes</i> 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 checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>H90X</i>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>1:45 P.M.</i> , from the causes and on the date stated above.	
22a. SIGNATURE (Degree or title) <i>Patrick L. Taylor, M.D., M.P.H.</i>		22b. ADDRESS <i>12000 Clark</i>	
22c. DATE SIGNED <i>3/3/52</i>		23. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>3-3-52</i>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <i>Edinburg, Ill.</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <i>MAR 3 1952</i> <i>J. Carl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Albert H. Hoppe, 4700 Washington Blvd.</i>	

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.....

Students of Mortuary College

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *James G. Lammer*

Licensed Embalmer No. *4142*

P. O. Address. *St Louis*

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.