

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. CITY OR TOWN St. Louis  
c. LENGTH OF STAY (in this place) 4 Days  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hosp.  
e. STREET ADDRESS (If rural, give location) 16 2842 Utah Pl. 21670

3. NAME OF DECEASED a. (First) Phillip b. (Middle) G. c. (Last) Sandel  
4. DATE OF DEATH (Month) (Day) (Year) August 9, 1954

5. SEX M. 6. COLOR OR RACE W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married  
8. DATE OF BIRTH July 20, 1880 9. AGE (In years last birthday) 74

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired  
10b. KIND OF BUSINESS OR INDUSTRY Carpenter  
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.  
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Phillip Sandel 13b. MOTHER'S MAIDEN NAME Not Known 14. NAME OF HUSBAND OR WIFE Elizabeth Sandel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  
16. SOCIAL SECURITY NO. 494-07-3909A  
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ollie Sandel 2842 Utah Pl.

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.  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Arteriosclerotic Hypertensive Cardiac Vascular Disease  
ANTECEDENT CAUSES (b) Cardiac Hypertrophy  
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (c) Bilateral Hydrocephalus  
11. OTHER SIGNIFICANT CONDITIONS Renal Coma  
INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 3 days

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? 442x

22. I hereby certify that I attended the deceased from 1-24-1951, to 8-9-1954, that I last saw the deceased alive on 8-9-1954, and that death occurred at 1:05 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. J. Reardon, M.D. 23b. ADDRESS 4390 Mead Pine Bl. 23c. DATE SIGNED 8-10-54

24a. BURIAL, CREMATION, REMOVAL OF BODY (Remove Rem) 24b. DATE 8-12-54 24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park 24d. LOCATION (City, town, or county) (State) St. Louis County Mo

DATE REC'D BY LOCAL AUG 11 1954 REGISTRAR'S SIGNATURE J. L. Ziegenhein & Sons 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 7027 Gravois

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.....  
Signature of Student Embalmer

Signed.....  
*Fred J. Ganner*

Licensed Embalmer No. *478*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.