

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40202**
Registrar's No. **1301**

FILED DEC 20 1954

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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

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) 11 yrs		d. STREET ADDRESS (If rural, give location) 529-1/2 South 15th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Methodist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) KAREN b. (Middle) ANN c. (Last) SABIN			4. DATE OF DEATH (Month) (Day) (Year) Dec. 6 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never Married	
8. DATE OF BIRTH June 22, 1943		9. AGE (In years last birthday) 11		IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementary School		11. BIRTHPLACE (State or foreign country) St. Joseph Missouri	
12. CITIZEN OF WHAT COUNTRY U S A					

13a. FATHER'S NAME Charles E. Sabin		13b. MOTHER'S MAIDEN NAME Geraldine Markum		14. NAME OF HUSBAND OR WIFE None	
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 Charles E. Sabin	
				ADDRESS St. Joseph, Mo.	

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) Diphtheria myocarditis			INTERVAL BETWEEN ONSET AND DEATH 2 days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diphtheria			2 weeks
		DUE TO (c) pharyngeal paralysis			2 days
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?	

22. I hereby certify that I attended the deceased from **Nov 22 1954**, to **Dec 6**, 1954, that I last saw the deceased alive on **Dec 6**, 1954, and that death occurred at **5:55P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. D. Wachter M.D.		23b. ADDRESS Kirkpatrick Bldg.		23c. DATE SIGNED 12-7-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 9, 1954		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	

DATE REC'D BY LOCAL REG. Dec 15, 1954		REGISTRAR'S SIGNATURE Kathleen M. Allison		FUNERAL DIRECTOR'S SIGNATURE Stamen Funeral Home	
				ADDRESS St. Joseph, Mo	

(Licensed Embalmers' Statement on Reverse Side)

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 Charles J. Bennett

Signed.....
Student Embalmer

Licensed Embalmer No. 4677

P. O. Address St Joseph Mo

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.