

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13848**
Registrar's No. **3386**

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 town) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5005 Tennessee Ave.		STREET ADDRESS (If rural, give location) 5005 Tennessee Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Louise b. (Middle) c. (Last) Sauerhage		4. DATE OF DEATH (Month) (Day) (Year) Apr. 13, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 23, 1874
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Berne, Switzerland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Wolf	
14. MOTHER'S MAIDEN NAME Mary Margaret		15. NAME OF HUSBAND OR WIFE Henry Sauerhage	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT'S SIGNATURE OR NAME Mrs. Cora Butler		19. ADDRESS Altadena, Calif.	
18. DATE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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.		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
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 5:11 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Catrol J. Taylor		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 4.15.55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Apr. 16, 1955		24c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	
24d. LOCATION (City, town, or county) (State) Glendale, California		DATE REC'D BY LOCAL REG. APR 15 1955	
REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Wacker - Selderle	
ADDRESS 3634 Gravois Ave.		E. P. (Licensed Embalmer's Statement on Reverse Side)	

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 *Robert Wheeler*

Licensed Embalmer No. *212*

P. O. Address *Stamps my*

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.