

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29387-58

58-016806

STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 999

1. PLACE OF DEATH a. COUNTY <i>St. Louis County</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <i>Richmond Heights</i> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			c. CITY OR TOWN <i>Fenton 4000</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Marys</i> Length of stay in 1b <i>2 days</i>			d. STREET ADDRESS (If outside, give location) <i>Summit Drive</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Mark</i> Middle <i>Gerard</i> Last <i>Sauer</i>			4. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>58</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/5/58</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>2</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (City and state or country) <i>Mo. 0</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Neil Sauer</i>		
14. MOTHER'S MAIDEN NAME <i>Leslynn Ann Benson</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Mr. Neil Sauer Summit Dr.</i> Address <i>Fenton, Mo.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure &amp; Atelectasis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Patent Foramen Ovale</i> DUE TO (c) <i>754.3</i>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>4:30</i> Month, Day, Year <i>April 58</i> a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>5 April 58</i> to <i>7 April 58</i> and last saw him alive on <i>7 April 58</i> . Death occurred at <i>4:30</i> pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Hubert A. Ritter M.D.</i>			22b. ADDRESS <i>16 Hampton Villa &amp; Plaza St. Louis 9 Mo.</i>		22c. DATE SIGNED <i>8 April 58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>4/9/58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
24. FUNERAL DIRECTOR <i>Jos. A. Howard</i>		ADDRESS <i>1619 So. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>4-8-58</i>	26. REGISTRAR'S SIGNATURE <i>Vertbert R. Donke M.D.</i>

health, Welfare public service  
 4005  
 300  
 1-56  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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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..... *Joseph A. Howard*

Licensed Embalmer No. *41*

P. O. Address *ST Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.