

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034657

STATE FILE NUMBER 8939

FILED SEP 25 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8939

300
1-57

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|---|-----------------------|---|--|--|--|--|--|---|--|
| 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, give TOWNSHIP only) OR TOWN St. Louis | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 38 2505 Watson Rd. | | Length of stay in lb 3 hrs | | d. STREET ADDRESS (If outside, give location) 2147 5879a Eichelberger | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lyford Vogt Sabourin | | | | 4. DATE OF DEATH Month Day Year Sept. 15 1958 | | | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 17, 1904 | | 9. AGE (In years last birthday) 54 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME Homer Sabourin | | | 13b. MOTHER'S MAIDEN NAME Un'kn | | | 14. NAME OF HUSBAND OR WIFE Ruth Sabourin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 437-09-3058 | | 17. INFORMANT Address Mrs.-Myrtle Welda 5879a Eichelberger | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary occlusion DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetic mellitus | | | | | | | 19. INTERVAL BETWEEN ONSET AND DEATH | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter number of injury in PART I or PART II of item 18.) Jagged Iron Duty Coin | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 9/17/58 | | | 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 420.0 | | |
| 21. I attended the deceased from Feb 17, 1956 to April 15, 1958 and last saw him alive on August 7, 1958 Death occurred at 12:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22. SIGNATURE (Degree or title) James J. Jannay Jr. M.D. | | | | 22b. ADDRESS 35 N. Central, Clayton 5 Mo | | | | 22c. DATE SIGNED Sept 16, 1958 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE Sept. 18, 1958 | | 23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Hoffmeister Colonial Mortuary 664 Chippewa St. St. Louis, Mo. | | | | 25. DATE RECD. BY LOCAL REG. SEP 17 '58 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. Do not use "concurrent," etc.; must use only standard nomenclature in item 18. No symptoms will be listed.

NGW 2 9 1967

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 *Eric C. Dranson*

Licensed Embalmer No. *4764*
P. O. Address *S. Lewis*

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.