

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003523

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **985**

FILED FEB 10 1959

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) Inside Limits
OR TOWNSHIP **St. Louis** Yes No

c. CITY OR TOWN **ST. LOUIS** Inside Limits
Yes No

c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb
HOSPITAL OR INSTITUTION **St. Louis City Hosp #1**

d. STREET ADDRESS (If outside, give location) Reside on Farm
223 ADDRESS 2624 Park Ave. Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Lillian Sondag

4. DATE OF DEATH Month Day Year
Jan 26 1959

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH **2-17-1892** 9. AGE (In years) **66** (at birthday) 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) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (City and state or country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **George Lay** 13b. MOTHER'S MAIDEN NAME **Virginia Emmon** 14. NAME OF HUSBAND OR WIFE **Joe Sondag**

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. **491-01-7697** 17. INFORMANT Address **Joe Sondag, 2624 Park Ave.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Diabetes Mellitus** INTERVAL BETWEEN ONSET AND DEATH **unk**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **260X**

DUE TO (c) **Chronic renal disease of unknown type**

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 NO **2**

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE WORK AT WORK 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 **12/18/58** to **1/26/59** and last saw her alive on **1/26/58**
Death occurred at **6:50 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Jean A. Chapman M.D.** 22b. ADDRESS **1515 Lafayette** 22c. DATE SIGNED **1/26/59**

23a. BURIAL CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **1-29-1959** 23c. NAME OF CEMETERY OR CREMATORY **Memorial Park Ceme.** 23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR ADDRESS **McLAUGHLIN'S, 2301 Lafayette Ave.** 25. DATE RECD. BY LOCAL REG. **JAN 28 '59** 26. REGISTRAR'S SIGNATURE **Loan G. ... M.D.**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *A. G. Ferris*

Licensed Embalmer No. *3384*

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.