

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007594

STATE FILE NUMBER

2 2126

FILED MAR 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
42
575
0

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | c. CITY OR TOWN <u>St. Louis</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hamilton med. center</u> | | d. STREET ADDRESS (If outside, give location) <u>5501 a. Chamberlain</u> | |
| Length of stay in 1b | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>B.</u> Last <u>SABIN</u> | | | 4. DATE OF DEATH Month <u>FEB</u> Day <u>28</u> Year <u>1959</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 20-1875</u> |
| 9. AGE (In years last birthday) <u>83</u> | 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) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (City and state or country) <u>Urbana Ill.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>Jacobi P. Gossett</u> | | 13b. MOTHER'S MAIDEN NAME <u>Maria Carnahan</u> | 14. NAME OF HUSBAND OR WIFE <u>EARL CALVIN SABIN</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT Address <u>MRS PHYLLIS McLENN 5501 a Chamberlain</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, general.</u> DUE TO (c) <u>420.0</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> |
| 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 type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year | | | |
| 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 <u>1-17-59</u> to <u>2-28-59</u> and last saw her <u>him</u> alive on <u>2-28-59</u> Death occurred at <u>270</u> P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Edward J. Berger MD</u> | | 22b. ADDRESS <u>457 N. Kuyphighway</u> | 22c. DATE SIGNED <u>3-1-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE <u>3/2/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crem.</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>C.P. Ruyton & Son 7233 Delmar</u> | | 25. DATE RECD. BY LOCAL REG. <u>MAR 2 59</u> | 26. REGISTRAR'S SIGNATURE (M.D.) <u>Earl Smith. M.D.</u> |

Dr: 266.

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Not Embalmed*
John J. Lupton
Licensed Embalmer No.
P. O. Address *St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.