

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020026

STATE FILE NUMBER

FILED JUN 12 1959

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

1545

5. 300

1-57

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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

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gardenville		c. CITY OR TOWN St Louis	
c. FULL NAME OF HOSPITAL OR INSTITUTION Miller Nursing Home		d. STREET ADDRESS 4965 Bonita	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Sax		4. DATE OF DEATH Month Day Year June 6, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stone Cutter	11. BIRTHPLACE (City and state or country) St Louis Mo.
13a. FATHER'S NAME Christ Sax		13b. MOTHER'S MAIDEN NAME not known	14. NAME OF HUSBAND OR WIFE <i>unk.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	17. INFORMANT Edna Lemp 4965 Bonita Address
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>arteriosclerotic Heart Disease</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Senility</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 Mon.</i> <i>6 Yrs.</i>
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 Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <i>Jan. 1956</i> to <i>June 6-1959</i> and last saw her/him alive on <i>6-1-59</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Eugene H. Edelle M.D.</i>		22b. ADDRESS <i>4971 Chumpeva St.</i>	
22c. DATE SIGNED <i>6-6-59</i>			
23a. BURIAL, CREMATION, REBURYAL (Specify) <i>Burial</i>		23b. DATE <i>6/8/59</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Laurel Hills Garden</i>		23d. LOCATION (City, town, or county) (State) <i>St Louis County Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>John L Ziegenhein & Sons 7027 Gravois</i>		25. DATE RECD. BY LOCAL REG. <i>6-6-59</i>	
26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>			

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 *Donald Berg*

Licensed Embalmer No. *4863*
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.