

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027738

FILED VS JUL 21 1959

Registration District No. 317 Primary Registration District No. 540 500 Registrar's No. 1782

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY St. Louis		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Johns		a. STATE Missouri		b. COUNTY St. Louis		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8130 Nola Ave.		Length of stay in lb 5 yrs.		c. CITY OR TOWN St. Johns		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 8130 Nola Ave.		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First HENRY		Middle ERNEST		Last SAAK		Month Day Year July 1 1959		
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-8-1891	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Chiropractor		11. BIRTHPLACE (City and state or country) Bernheimer, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME August Sack			13b. MOTHER'S MAIDEN NAME Amoena Lieneke		14. NAME OF HUSBAND OR WIFE Laura Kurtz Sack			
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. 498-38-7482		17. INFORMANT Laura Sack,		Address above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Acute Pulmonary Infarction				EMIX.				
DUE TO (b) Intravascular Clot				several days				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic cardiac failure, A.S.H.D.				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
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 4-28-59 to _____ and last saw him/her alive on June 1, 59 Death occurred at July 1, 1959 12:30 a. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE A. J. Steiner		(Degree or title) M.D.		22b. ADDRESS 3720 Washington Blvd. St. Louis, Mo.		22c. DATE SIGNED 7-2-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-3-1959	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)		
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo.			ADDRESS		25. DATE RECD. BY LOCAL REG. 7-3-59		26. REGISTRAR'S SIGNATURE John C. Murphy MD	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.