

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS APR 22 1960

-60-017931

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1057 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sappington</u>	Length of stay in 1b <u>6 Weeks</u>	c. CITY OR TOWN <u>Cedar Hill Mo.</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>11144 Pine Forest Dr</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lake Adele Rtl Box 40</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>MEMPHIS</u> First <u>V</u> Middle <u>SONDERMANN</u> Last	4. DATE OF DEATH <u>3-28-1960</u> Month Day Year
--	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-1909</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
----------------------	-------------------------------	---	------------------------------------	----------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during past 12 months (If none, state if retired)) <u>Practical Nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Coffeen Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	---	--

13a. FATHER'S NAME <u>Milton Lang</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Lang</u>	14. NAME OF HUSBAND OR WIFE <u>Ignatius Sondermann</u>
---------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-40-4427</u>	17. INFORMANT <u>Ignatius Sondermann Cedar Hill Mo.</u> Address <u>RT. 1 Box 40</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>Carcinomatosis generalized</u> DUE TO (b) <u>Carcinoma of gall bladder</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Month, Day, Year a.m. p.m.

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>Dec 24, 1959</u> to <u>death</u> and last saw her/him alive on <u>March 24, 1960</u> Death occurred at <u>@ 5:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph C. Ingram, M.D.</u>	22b. ADDRESS <u>3284 Ivanhoe Ave.</u>	22c. DATE SIGNED <u>3-29-60</u>
--	---------------------------------------	---------------------------------

23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Funeral</u>	23b. DATE <u>3-31-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hills Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u>
--	----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>WINGBERMUEHLE 3819 So Grand Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>3-29-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
---	---	--

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 George J. W. Wampler
Licensed Embalmer No. 4611

P. O. Address St Louis 18

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.