URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-024933
STATE FILE NUMBER

FILED VS JUL 12 1960

ENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6592

1. PLACE OF DEATH a. COUNTY	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 ST. LOUIS MO — Length of stay in 1b 14 DAYS	c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEACONESS HOSPITAL — Inside Limits Yes ☑ No ☐	d. STREET ADDRESS (If outside, give location) 3701 A WYOMING ST — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print)	First: CARL	Middle: —	Last: SAUERLAND	4. DATE OF DEATH Month 6 Day 27 Year 1960
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 4-1-1900	9. AGE (last birthday): 60 — 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): DRILL PRESS OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY: MC DONNELL AIRCRAFT	11. BIRTHPLACE (City and state or country): WERL WEST PHILIA, GERMANY	12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13a. FATHER'S NAME: THEODORE SAUERLAND	13b. MOTHER'S MAIDEN NAME: JOSEPHINE MUELLER	14. NAME OF HUSBAND OR WIFE: ANNA LEE SAUERLAND		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 492-07-3023	17. INFORMANT: MRS. ANNA LEE SAUERLAND Address 3701 A WYOMING		

MEDICAL CERTIFICATION

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)	myocardial infarction	
DUE TO (b)	antroseptal myocardial infarction	2 weeks
DUE TO (c)	atherosclerosis 420.1	2 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

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 a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE 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 6/13/60, to 6/27/60 and last saw her/him alive on 6/27/60

Death occurred at 1 05 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James O. Wood	(Degree or title) James O. Wood MD	22b. ADDRESS 8230 Forsythe 8230 Forsythe	22c. DATE SIGNED 6/28/60
23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL	23b. DATE: 7-1-1960	23c. NAME OF CEMETERY OR CREMATORY: MULKEYTOWN CEMETERY	23d. LOCATION (City, town, or county) (State): MULKEYTOWN, ILL.
24. FUNERAL DIRECTOR: HOWARD H. MICHEL	ADDRESS: 5930 SOUTHWEST	25. DATE RECD. BY LOCAL REG.: JUN 28 1960	26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed V E Morris

Signature of Student Embalmer

Licensed Embalmer No. 336

P. O. Address St Louis

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