SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-021598

STATE FILE NUMBER

AMENDED

Registration District No. 146 Primary Registration District No. 3370 Registrar's No. 305

FILED JUN 20 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: BUCKNER
Length of stay in 1b: 80 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: RURAL ROUTE # 1
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: BUCKNER
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Rural Route # 1
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: ALFRED Middle: SAUERBIER Last:
4. DATE OF DEATH: Month: JUNE Day: 8, Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9-11-1875
9. AGE (last birthday): 85
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): HORSE SHOER
10b. KIND OF BUSINESS OR INDUSTRY: HORSE SHOER
11. BIRTHPLACE (City and state or country): INDEPENDENCE, MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: JOHN F. SAUERBIER
13b. MOTHER'S MAIDEN NAME: HENRIETTA SHERSCHFELD
14. NAME OF HUSBAND OR WIFE: JANE SAUERBIER- Dec'd.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Leopold W. Sauerbier, R.R. # 1, Buckner, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): arterio sclerosis
DUE TO (c):
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 May 23, 1961, to June 8 '61 and last saw ~~her~~ him alive on June 7, 1961.
Death occurred at 4:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John L Weisler (Degree or Title) D.O.
22b. ADDRESS: Buckner, mo.
22c. DATE SIGNED: 6-9-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 6-10-61
23c. NAME OF CEMETERY OR CREMATORY: WOODLAWN CEMETERY
23d. LOCATION (City, town, or county) (State): INDEPENDENCE, MO.

24. FUNERAL DIRECTOR ADDRESS: GEO. C. CARSON & SONS, INDEPENDENCE, MO.
25. DATE RECD. BY LOCAL REG.: 6-10-61
26. REGISTRAR'S SIGNATURE: Ella L. Craig

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Dean W. Huff

Signature of Student Embalmer

Licensed Embalmer No. 7914

P. O. Address Indep., 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.