

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9802**
Registrar's No. **1226**

Registration District No. **399** Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months 6 days
(Specify whether _____)
In this community 5 Months
years, months or days)

3. (a) PRINT FULL NAME Dr. Albert O Sage **700**
(b) If veteran, name war No (c) Social Security No. No

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Beatrice Sage 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased May, 4, 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist

11. Industry or business _____
12. Name Unknown Sage **9**
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Beatrice Sage
(b) Address Concordia, Kansas

17. (a) Removal (b) Date thereof 3-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington, Kansas

18. (a) Signature of funeral director D. H. Newcomer, Son
(b) Address 1401 Brush Creek Blvd.
19. (a) Mch 19, 1940 M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Kansas
(a) State _____ (b) County _____
(c) City or town Concordia
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 19th
year 1940 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 15, 1940 to March 19, 1940
that I last saw him alive on March 19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary edema
Duration _____

Due to 45
Due to _____

Other conditions: Couph pneumonia
(Include pregnancy within 3 months of death)

Major findings: Dissection of the heart
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. or other) M.D.
Address 330 Hayes Blvd Date signed 3/19/40

830 Cuyler Bldg
1:30-4:00 P.M.

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address Kemo

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 this body is not embalmed, above space should be left blank.