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10286

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

Registration District No. 7911

Primary Registration District No. 1005

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME William Edward Sackett

8. (b) If veteran, name war None 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hedvig Sackett 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased December 22, 1900
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 11 21 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Bread Wrapper

11. Industry or business _____

12. Name Thomas Sackett

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Katie Royer

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hedvig Sackett

(b) Address 4118 North Taylor Ave.

17. (a) Burial (b) Date thereof 12/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 4704 Washington Blvd

19. (a) DEC 16 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 10
(If outside city or town limits, write "RURAL")
(d) Street No. 4118 North Taylor
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 13
year 1940 hour 2 minute 25 P. M.

21. I hereby certify that I attended the deceased from
December 6, 1940 to December 13, 1940;
that I last saw him alive on December 13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease Duration
Aortic and mitral stenosis and
insufficiency.
~~and~~ Broncho pneumonia

Due to _____
Other conditions _____
(Includes pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy As above

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?

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other)
Address BARNES HOSPITAL Date signed _____

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

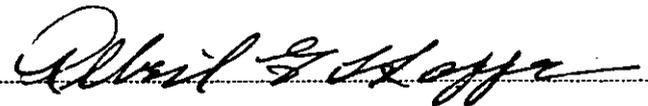
FORM 5-17-39
U. S. GOVERNMENT PRINTING OFFICE: 1938

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.....



Licensed Embalmer No. 3971.....

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