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MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 34649
9489
Registrar's No. _____

FILED NOV 12 1948
Registration District No. 318

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution ST. JOHNS 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

3. (a) PRINT FULL NAME John J. Sartorius
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M, U 5. Color or race W
6. (a) Single, widowed, married, divorced 2-widowed
6. (b) Name of husband or wife MARTHA ANN SARTORIUS
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JUNE 16 1863
(Month) (Day) (Year)

8. AGE: Years 85 Months 4 Days 13
If less than one day _____ hr. _____ min.

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

10. Usual occupation NIL

11. Industry or business _____
12. Name MARTIN SARTORIUS
13. Birthplace St. Louis, Germany
(City, town, or county) (State or foreign country)
14. Maiden name MARY EIMER
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Olivia Schammacher
(b) Address 4253A, S. Kingshighway

17. (a) BURIAL (b) Date thereof Nov 2-48
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation S. PETER + PAULS.

18. (a) Signature of funeral director E. J. Schur
(b) Address 3125 Lafayette St.
19. (a) NOV 1 1948 (b) J. B. Pasalar
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 4253A S. Kingshighway
14 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 29
year 1948 hour 9 minute 00 p.m.
21. I hereby certify that I attended the deceased from Mar. 24 1948 to Oct. 29 1948
that I last saw him alive on Oct. 29 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of left ventricle
Due to _____
Due to _____
Other conditions Carcinoma of Sigmoid Colon
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of Sigmoid Colon
Of operations _____
Of autopsy as above

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 Thomas A. Coates (M. D. or other) MD
Address 4922 Hampton Date signed 11/1/48

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

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.....

Joseph D. Miller

Licensed Embalmer No. *4014*

P. O. Address *3125 S. 2nd St. #4*

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, fact should be so stated above.