

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

27041

State File No. 3467

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3467</u>		
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Green</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>10 mos.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookline Station</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Campbell Conv. Home</u>				d. STREET ADDRESS (If rural, give location) <u>X</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alfred</u>			b. (Middle) <u>H.</u>		c. (Last) <u>SAGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 10, 1949</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>married</u> (Specify)		8. DATE OF BIRTH <u>2-28-72</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Joseph Sager</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Hanley</u>		14. NAME OF HUSBAND OR WIFE <u>Myrtle Sager</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME. ADDRESS <u>Rowland Sager, 5522 Lamar, Mission, Kansas</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. - It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>						<u>5 days</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac Decompensation</u>						<u>3 weeks</u>	
	DUE TO (c) <u>Atherosclerotic Heart Disease</u>						<u>3 years</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Paralysis Agitans</u>						<u>10 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>48</u> , to <u>Aug 10</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Aug 10</u> , 19 <u>49</u> , and that death occurred at <u>3552 m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Jack W. Wolf</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>206 Apple St. Kansas City, Mo.</u>		23c. DATE SIGNED <u>Aug 10-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-11-49</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Republic, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>8-11-49</u>		REGISTRAR'S SIGNATURE <u>Steraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Eylar, Kansas City, Mo.</u>				

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

Dr. Gustav Stett.
Hennrich Hospital.

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
Student Embalmer

Signed Edw E Heck

Licensed Embalmer No. 4063

P. O. Address H. C. 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 this body is not embalmed, fact should be so stated above.