

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2979

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 485

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Decatur 812.0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) 2159 East Eldorado			

3. NAME OF DECEASED (Type or Print) Robert B. Sattley			4. DATE OF DEATH (Month) (Day) (Year) Jan. 15, 1950		
--	--	--	--	--	--

5. SEX Male (1)	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 4, 1906	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
--------------------	---------------------------	---	----------------------------------	---------------------------------------	---------------------------	-------------------------	-------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Commissioner	10b. KIND OF BUSINESS OR INDUSTRY City of Decatur	11. BIRTHPLACE (State or foreign country) Decatur, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	-------------------------------------

13a. FATHER'S NAME Robert L. Sattley	13b. MOTHER'S MAIDEN NAME Belle Oder	14. NAME OF HUSBAND OR WIFE Lucille Sattley
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. UNK.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Sattley, Decatur, Illinois
---	---------------------------------	---

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, asthma, 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) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Subdural hemorrhage, suffered in collision between auto driven by deceased + automobile driven by one Albert Kuehnleber on Highway #66 near Lincoln Ill Logan County, on Dec 11, 1949 about 8:30 pm Cause + manner of same could not be determined. Open Verdict	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Open Verdict	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Decatur (ILL.)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) Dec 11 49 P.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 26
--	--	----------------------------------

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:25 P. m., from the causes and on the date stated above.

23a. SIGNATURE Patricia E. Taylor, Coroner	(Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 1-16-50
---	-------------------	----------------------------	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-16-50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Decatur, Illinois
--	----------------------	------------------------------------	--

DATE REC'D BY LOCAL REG. JAN 16 1950	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington
---	-----------------------	---

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

[Handwritten mark]

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 *Robert M Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.