

FILED AUG 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 28619

Registrar's No. 6976

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>4209 McRee</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mimie</b>		b. (Middle) <b>Bush</b>		c. (Last) <b>Saebens</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 15, 1950</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Nov. 24, 1882</b>	
9. AGE (In years, last birthday) <b>68</b>		IF UNDER 1 YEAR Months <b>8</b>		IF UNDER 24 HRS. Days <b>21</b>		Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Des Moines Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Dont Know</b>		13b. MOTHER'S MAIDEN NAME <b>Dont Know</b>		14. NAME OF HUSBAND OR WIFE <b>John Saebens</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Irene Saebens Maddox 4270 Castlemans Ave</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>cerebral thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis, gen.</b> DUE TO (c) <b>Diabetes mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>years</b>  <b>2 years</b>	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>3/3 2X</b>			
22. I hereby certify that I attended the deceased from <b>June 1949</b> to <b>Aug. 15, 1950</b> , that I last saw the deceased alive on <b>Aug 15, 1950</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Max S. Franklin, M.D.</b>				23b. ADDRESS <b>634 N. Grand</b>		23c. DATE SIGNED <b>8/16/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Aug. 17, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
DATE REC'D BY LOCAL BOARD <b>AUG 1 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Foster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thos. J. Finan and Sons 1519 S Grand</b>			

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

**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.....

**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.**