

FILED OCT 20 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33816**  
**4291**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
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>Jackson</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>64 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>				d. STREET ADDRESS (If rural, give location) <u>2320 Quincy</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u>		b. (Middle) <u>H.</u>		c. (Last) <u>Sackewitz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 6 51</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>8/21/1885</u>			
9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (In years last birthday) <u>66</u>			
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Carl Sackewitz</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Saulu</u>			
14. NAME OF HUSBAND, OR WIFE <u>Leona Gabberry</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>331-07-2129</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Leona Sackewitz</u> ADDRESS <u>2320 Quincy</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____				DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				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) _____		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? _____					
22. I hereby certify that I attended the deceased from <u>Oct. 6</u> , 19 <u>51</u> to <u>Oct. 6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Oct. 6</u> , 1951, and that death occurred at <u>12:18P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>B.I. Burns</u> (Degree or Title) _____				23b. ADDRESS <u>24th &amp; Cherry</u>		23c. DATE SIGNED <u>10-8-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/9/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>			
DATE REC'D BY LOCAL REG. <u>10-8-51</u>		REGISTRAR'S SIGNATURE <u>Deraldine Holman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Shiel</u>		ADDRESS <u>K.P. Shiel</u>			

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

*R. Fleming*

**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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed *Richard E. Carroll*.....

Signed.....  
Student Embalmer

Licensed Embalmer No. *4859*.....

P. O. Address *K. 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.