

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10612

State File No.

318

1003

2951

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place)		2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 4605 Lindell Blvd	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) A. c. (Last) SONNENDAY			4. DATE OF DEATH (Month) (Day) (Year) MARCH 28 1952		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH March 27, 1888		9. AGE (In years last birthday) 64		# UNDER 1 YEAR Months Days # UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent.		10b. KIND OF BUSINESS OR INDUSTRY Kroeger Company		11. BIRTHPLACE (City and State or Foreign Country) Cleves, Ohio /	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME John William Sonnenday.		13b. MOTHER'S MAIDEN NAME Hattie Leverenz.		14. NAME OF HUSBAND OR WIFE Emma B. Sonnenday.	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 269-07-2273		17. INFORMANT'S SIGNATURE OR NAME Mrs. Emma B. Sonnenday., St. Louis, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 15 hours	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) RUPTURED THORACIC AORTA (non-syphilitic)				15 years	
		ANTECEDENT CAUSES DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE					
		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"/>	
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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)	
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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? H43X	
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22. I hereby certify that I attended the deceased from 3/27, 1952, to 3/28, 1952, that I last saw the deceased alive on 3/28, 1952, and that death occurred at 12:08 Pm., from the causes and on the date stated above.

23a. SIGNATURE G. D. Vermillion M.D. 0		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 3/28/52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		24b. DATE Mar. 31, 1952		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
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DATE REC'D BY LOCAL REG. MAR 29 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd.,	
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(Licensed Embalmer's Statement on Reverse Side)

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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.