

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35915**
9084

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL #1		e. STREET ADDRESS (If rural, give location) 23 1918a South Broadway, 223/0	
3. NAME OF DECEASED (Type or Print) a. (First) Betty		b. (Middle) Lee	
c. (Last) Sackett		4. DATE OF DEATH (Month) (Day) (Year) Oct. 5, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 14th, 1900
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (City and State or Foreign Country) Piedmont, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Jasper Babb	
13b. MOTHER'S MAIDEN NAME Mary Black		14. NAME OF HUSBAND OR WIFE Thomas Sackett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Thomas Sackett, 1918a S. Broadway		ADDRESS	
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) Coronary infarction INTERVAL BETWEEN ONSET AND DEATH 8 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Auricular fibrillation & embolization. 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 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 465X		22. I hereby certify that I attended the deceased from Sept. 28, 1954 , to Oct. 5, 1954 , that I last saw the deceased alive on Oct. 5, 1954 , and that death occurred at 11:55 AM , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) John A. Bergmann M.D.		23b. ADDRESS 1515 Lafayette Ave.	
23c. DATE SIGNED 10-7-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 10/8/54		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE CARVIN P. FEUTZ	
DATE REC'D BY LOCAL REG. OCT 7 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
26. FUNERAL HOME, INC., St. Louis, 15, Missouri.		ADDRESS 4828 Natural Bridge Blvd.	

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.....
Signature of Student Embalmer

Signed *John A. Mills*.....

Licensed Embalmer No. *418*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.