

FILED NOV 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32473

State File No.

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 417

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give OR township) <u>CAPE GIRARDEAU</u> c. LENGTH OF STAY (in this place) <u>11 DAYS</u>		c. CITY OR TOWN <u>CHAFFEE</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CAPE OSTEPATHIC HOSP</u>		STREET ADDRESS (If rural, give location) <u>126 GOOSE AVE.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MONROE</u> b. (Middle) <u>CECIL</u> c. (Last) <u>SADLER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 28 1955</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>AUG 10 1898</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>MEYERS MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>ALBERT SADLER</u>	13b. MOTHER'S MAIDEN NAME <u>JULIA WARREN</u>	14. NAME OF HUSBAND OR WIFE <u>ADA SADLER</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no 4-14-1919</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Ada Sadler Chaffee Mrs</u>	ADDRESS <u></u>
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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, asthenia, 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) <u>Acute Cardiac arrest</u>		<u>10 min.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Surgical shock</u> DUE TO (c) <u>Intestinal obstruction</u>		<u>12:30 AM.</u> <u>1 month.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Bronchiectasis and Bronchial asthma 5705</u>		<u>since 1919</u>	

19a. DATE OF OPERATION <u>10/28/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>acute obstruction of jejunum massive diverticulosis</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., on or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>none</u>
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22. I hereby certify that I attended the deceased from 8-25, 1954, to 10-28, 1955, that I last saw the deceased alive on 10-28, 1955, and that death occurred at 12:30 AM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Halter H. Lehmyer, D.O.</u>	23b. ADDRESS <u>Chaffee, Missouri</u>	23c. DATE SIGNED <u>10/31/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>OCT. 31-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK CEM. CHAFFEE MO</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>11-1-55</u>	REGISTRAR'S SIGNATURE <u>W. C. Summers</u>	44-0	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Hubbs Chaffee Mrs.</u>	ADDRESS <u></u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SECRET

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.....
[Handwritten Signature]

Licensed Embalmer No. 38
P. O. Address Cape Girardeau

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.