

FILED JAN 14 1958

STATE FILE NUMBER

69

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. _____

300
1-57

D

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS COUNTY MONTGOMERY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN IRVING Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 915 No. Grand VETS ADM. HOSPITAL		Length of stay in lb 15 Days	d. STREET ADDRESS (If outside, give location) 32 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle LOUIS Last SAPP			4. DATE OF DEATH Month 1- Day 3- Year 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-93
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLASS FACTORY WORKER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) LEBANON KENTUCKY
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME SAMUEL D. SAPP	
13b. MOTHER'S MAIDEN NAME MAGNORA SAPP		14. NAME OF HUSBAND OR WIFE ROSE SAPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> unknown) (If yes, give unit or dates of service) WW-I		16. SOCIAL SECURITY NO. 334-12-3951	
17. INFORMANT VAH RECORDS 915 N. GRAND ST. LOUIS, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE - UREMIA DUE TO (b) DIABETIC NEPHROPATHY DUE TO (c) GENERALIZED SEPSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 260x
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION VA		COUNTY STATE	
21. I attended the deceased from 12-19-57 to 1-3-58 and last saw him live on 1-3-58 Death occurred at 7:10 PM. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert B. Stell (Degree or title) M.D.		22b. ADDRESS VAH ST. LOUIS, MISSOURI	
22c. DATE SIGNED 1/9/58		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-4-1958	
23c. NAME OF CEMETERY OR CREMATORY St. Agnes Cem.		23d. LOCATION (City, town, or county) Hillsboro, Illinois	
24. FUNERAL DIRECTOR Harley Carroll, Litchfield, Ill.		25. DATE RECD. BY LOCAL REG. JAN 4 '58	
26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.			

HSR

STATEMENT BY LICENSED EMBALMER

Not

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 *Frank Carroll Funnell*

Licensed Embalmer No.
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.