

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034677

STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8800

5. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp #1		d. STREET ADDRESS (If outside, give location) 2269 916 Montgomery St.	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie (nmi) Schone		4. DATE OF DEATH Month Day Year Sept 10 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1892
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Home	9c. AGE (In years last birthday) 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	10c. AGE (In years last birthday) 63
11. BIRTHPLACE (City and state or country) St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME unk.		13b. MOTHER'S MAIDEN NAME unk.	
14. NAME OF HUSBAND OR WIFE unk.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ida Overman 4718 Farlin Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fecal Peritonitis DUE TO (b) Perforated Gastric Ulcer DUE TO (c) 540.1 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
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 <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 COUNTY STATE	
21. I attended the deceased from 9-8-58 to 9-10-58 and last saw her alive on 9-10-58 Death occurred at 12:03 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Michael S. Passoway MD		22b. ADDRESS 1515 Lafayette Ave.	
22c. DATE SIGNED 9-10-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 9/12/58		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) St. Louis		23e. STATE Mo.	
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis AVE.		25. DATE RECD. BY LOCAL REG. SEP 1 1958	
26. REGISTRAR'S SIGNATURE J. Carl Smith Mo 7183			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *JEMoore*

Licensed Embalmer No. *3360*

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.