

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000523
STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. 53 Primary Registration District No. _____ Registrar's No. 43

300
-57

Health,
Welfare
Public
Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only statements recommended. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Miller ville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Miller ville</u> <u>0160</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Miller ville R</u>		Length of stay in 1b <u>18 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>1 mile north</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle _____ Last <u>Sachse</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11, 1894</u>
9. AGE (In years last birthday) <u>62</u>		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) <u>Meat Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Packing plant</u>	11. BIRTHPLACE (City and state or country) <u>Frederick, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>William S. Sachse</u>	
13b. MOTHER'S MAIDEN NAME <u>Rosina Schaefer</u>		14. NAME OF HUSBAND OR WIFE <u>Elizaunger Sachse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. John Davis Cape Gir. Mo.</u> 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) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypochromic Anemia.</u>			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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 <u>1-16-59</u> to <u>1-27-59</u> and last saw him alive on <u>1-27-59</u> Death occurred at <u>7:12 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. N. Jager M.D.</u>		22b. ADDRESS <u>Jackson Mo</u>	22c. DATE SIGNED <u>1-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Jan 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau Mo.</u>
24. FUNERAL DIRECTOR <u>H. C. Crocraft</u>	ADDRESS <u>Jackson Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 4, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u>

APR 6 1959

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 *Lyman Stecher*

Licensed Embalmer No. *2476*
P. O. Address *Jackson*

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.